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VOLUME I

MEDICAID MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN FOR TITLE XIX

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service

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16. Abstracts THE MODEL MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) IS AN INTEGRATED GROUP OF PROCEDURES AND COMPUTER PROCESSING OPERATIONS (SUBSYSTEMS) DEVELOPED AT THE GENERAL SYSTEMS DESIGN LEVEL TO MEET TWO PRINCIPAL OBJECTIVES: (A) EFFECTIVELY PROCESS AND CONTROL CLAIMS AND PROVIDE STATE MANAGEMENT WITH THE NECESSARY INFORMATION FOR PLANNING AND CONTROL; (B) USAGE BY ALL STATES AND JURISDICTIONS ENGAGED IN THE TITLE XIX PROGRAM. THE MMIS IS AN INTEGRATED MANAGEMENT INFORMATION SYSTEM THAT CAN BE APPLIED TO A WIDE RANGE OF ADMINISTRATIVE AND MANAGEMENT FUNCTIONS INCLUDING RECIPIENT ELIGIBILITY, PROVIDER ENROLLMENT, CLAIMS PROCESSING AND PAYMENT SURVEILLANCE AND UTILIZATION REVIEW, AND MANAGEMENT AND ADMINISTRATIVE REPORTING. THE OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR INFORMATION SYSTEMS IS ENCOURAGING STATES TO INSTALL ALL OR PARTS OF THE MMIS DEPENDING UPON INDIVIDUAL CIRCUMSTANCES AND THE NEED FOR IMPROVEMENT.

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MEDICAID
MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN
FOR TITLE XIX

VOLUME I: Recipient Subsystem and Provider Subsystem

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social And Rehabilitation Service
Associate Administrator For Information Systems

Division of Medicaid Systems
SRS-75-06001

FOREWORD

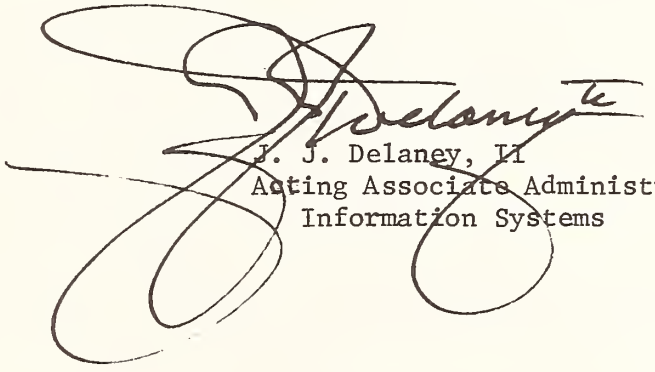
This five volume set covering the General System Design for the Medicaid Management Information System (MMIS) represents an update to the original issuance of August 1971. The credibility which this general design has maintained over the past three years and the several State implementations attest to the fulfillment of our earlier stated mission to provide a system "to improve Medicaid Management Information and Claims Processing Systems for greater effectiveness in the administration and delivery of health care services."

This general design can be applied to any State or jurisdiction regardless of size or magnitude of the Title XIX program in effect.

The design, its functional requirements and objectives, also represents the criteria on which States are measured for conformance to receive the increased Federal financial matching for claims processing and information retrieval systems as provided in Section 235 of Public Law 92-603.

This update reflects program changes and new requirements for Long Term Care; Title XVIII Cost Ceilings; Recipient Cost Sharing; Early and Periodic Screening, Diagnosis and Treatment; and for Institutional Services and Reviews. To further support these and other program requirements, several new data elements have been added.

The Division of Medicaid Systems is now responsible to the Associate Administrator for Information Systems. Though this represents a major organization change since the original issuance of the general design and increased relative importance of Medicaid, the program requirements continue to be refined and new specifications will develop for new program needs. The General System Design facilitates a practical feature for continuing periodic updates as provided for in the original issuance.



J. J. Delaney, II
Acting Associate Administrator for
Information Systems

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The acknowledgements contained in the Foreword of August 1971 are included below to acknowledge our appreciation to earlier contributors, many of whom continue to aid in the maintenance of the General Systems Design.

Many individuals and organizations directly and indirectly made this MMIS possible. Appreciation is expressed to the following who furnished valuable suggestions, constructive criticism, and continuous cooperation prior to and during the development of the MMIS; W. R. Berry and E. A. Diephaus, Office of the Secretary, DHEW; Dr. E. W. Brian and M. L. Shields, California; C. T. Berkins and Dr. Frank Bowling, Colorado; R. G. Wessel, Illinois; Dr. J. J. Callahan, Massachusetts; Stuart Paterson, Michigan; G. W. Peterson and L. I. Peterson, Minnesota; D. H. Forck, Missouri; Mr. W. J. Jones, Boniface Damaina, Dr. George Hood, George Fleming, and Martin Platzner, New Jersey; Dr. C. C. Nuckhols, Jr., and Peter Trainor, New York; J. E. Hansan, J. C. Minnis, and F. J. Zuber, Ohio; C. F. McDermott and Dr. Bertha Levy, Oklahoma; Mr. Glenn Johnson and W. G. Shoemaker, Pennsylvania; Dr. P. J. Pesare and Anthony Barile, Rhode Island; F. D. Lockhart, South Carolina; Weldon Adams, Tennessee; Dr. P. A. Gates, Texas; Paige Skaggs, Jr., Dr. James Mangus and Helen Condry, West Virginia; John Murphy, Wisconsin; Tom Jones, consultant, New York; R. J. Terkhorn, Eli Lilly and Company, Vernon Trygstad and Claude Timberlake, National Pharmaceutical Council; R. E. Abrams, Paid Prescriptions; J. A. O'Brien, Brandon Applied Systems; H. S. Colby, Colby Group, Inc.; T. M. Tierney, Charles Pace, William Blackburn, Sol Sherman, E. E. Rawson, W. H. Hogsten, and J. P. Coughlin, Social Security Administration; L. B. Genebach, Jr., D. A. Roache, J. J. Trainor, and G. E. Saxon, Social and Rehabilitation Service; and the Medical Services Administration's Central Office and Regional Office staffs.

There are others too numerous to name who also gave their assistance in completing this project. To those unnamed, we gratefully acknowledge your contributions.

November 1, 1974

MEDICAID
MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

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INTRODUCTION

A. GENERAL

The General Systems Design of the Model Medicaid Management Information System is a product of the Division of Management Information and Payment Systems, Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

The General Systems Design is comprised of an introduction, a management overview or executive brief, six sections describing individual subsystems within the Model System, and an Appendix. This material has been grouped for convenience of handling into five volumes.

B. DOCUMENTATION ORGANIZATION

The General Systems Design documentation for each of the six subsystems that make up the Model System is presented within its respective section as follows:

1. Subsystem summary, where the subsystem objectives are itemized and a general description of the subsystem is provided.

2. Design elements, where all assumptions and constraints imposed are listed, where considerations affecting the design of the subsystem are discussed, and where the controls and audit trails established to insure subsystem integrity are listed.

3. Processing flow, where a detail description is furnished of how each module functions within the subsystem.

4. Subsystem outputs, where each major output is defined as to purpose, distribution, content, and format.

5. Subsystem inputs, where each major input is defined as to use, source, and data element content.

6. Subsystem files, where each major file is defined as to function and data element content.

7. Input/Output matrix, where data elements used in a subsystem are identified as to their source and distribution.

Volume V - Appendix contains the following General Systems Design documentation:

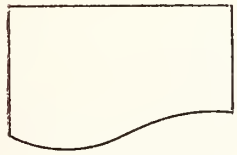
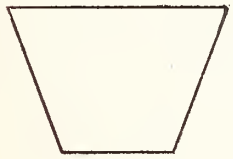
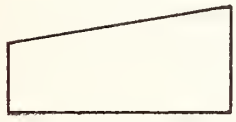
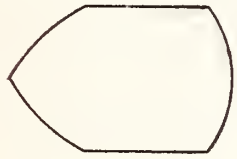
1. A glossary which indicates the specialized meaning of various terms used in the design documentation.

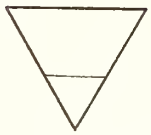
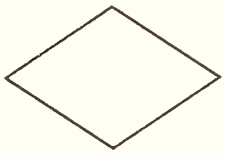
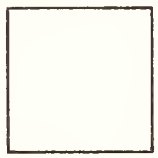
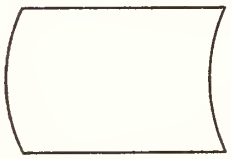
2. Data element definitions which provide an explanation of each data element, and where applicable, a recommended code structure.

C. FLOWCHART SYMBOL EXPLANATION

In certain portions of the General Systems Design documentation flowcharts are used to graphically describe the processing flow. An explanation of the symbols employed is furnished on the following pages.

FLOWCHART SYMBOLS

SYMBOL	EXPLANATION
	Terminal point - indicates exit from a module to another module or subsystem; indicates entry to a module from another module or subsystem.
	Document - computer printed output; manually created reports; source documents.
	Manual process step - a step in which no equipment, other than normal clerical devices, is used.
	Keying - a process step involving the generation of machine-readable records using a key-driven device.
	Manual input - information input by on-line keyboards.
	Display - information display by on-line video devices.
	Computer processing step - processing which takes place in the computer.

SYMBOL	EXPLANATION
	Off-line file - a file of non-machine-readable data such as documents.
	Decision - a processing step (manual or computer) in which a decision is made and one of several alternatives selected.
	Off-line equipment processing - a processing step which utilizes off-line equipment (e.g., sorter, microfilm machine).
	Input/Output function in card medium.
	On-line file - a file composed of machine-readable data (e.g., drums, tape, disk).
	On-page connector - indicates entry to a process from a point on the same page; indicates exit to a process on the same page.
	Off-page connector - indicates entry to a process from another page; indicates exit to a point on another page.

D. DOCUMENTATION NOMENCLATURE

1. Design Element Identification

As a part of the General Design documentation for individual subsystems, specifications for inputs, outputs, and data files are provided. To provide a means of unique identification for these design elements, the following reference scheme is used:

XX-Y-ZZ

where XX identifies the source subsystem for the design element per the following abbreviations:

- RS Recipient Subsystem
- PS Provider Subsystem
- CP Claims Processing Subsystem
- RF Reference File Subsystem
- SU Surveillance and Utilization Review Subsystem
- MR Management and Administrative Reporting Subsystem

where Y identifies the design element per the following code:

- O Output
- I Input
- F File

where ZZ is a unique two digit number identifying the particular design element.

2. Data Element Numbering

Each subsystem serves as a point of entry for various data elements that are collected, processed, and displayed on one or more outputs from the Model System. The following ranges of numbers are allocated by subsystem for assignment to data elements that originate in that subsystem.

- 100-199 Recipient Subsystem
- 200-299 Provider Subsystem
- 300-499 Claims Processing Subsystem

500-599	Reference File Subsystem
600-699	Management and Administrative Reporting Subsystem
700-799	Surveillance and Utilization Review Subsystem

3. Flowchart Connectors

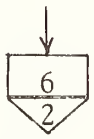
As a part of the documentation of each subsystem, module flowcharts are furnished to describe the processing flow. In some instances, more than one flowchart page is required for a module. This situation results in the need for processing connectors as follows:

where X is the number of a specific flowchart page. If the flowchart indicates an exit connector, then X is the page to which exit is made. If the flowchart indicates an entry connector, then X is the page upon which entry is made.

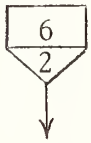
Y is a unique number designating a particular exit or entry point on the page.

For example:

From Page 4 exit connector



To Page 6 entry connector



E. TRANSMITTAL OF REVISIONS

The General Systems Design is being furnished in Perfect binding to facilitate periodic addition of new material or changes to the existing material. All changes and/or additions will be furnished under a transmittal number. The form on the following page should be placed in the front of this volume and maintained according to the instructions thereon.

For those who desire to incorporate pages in the manuals for their own reference use, it is recommended that they maintain a separate record index in the front of this volume, and employ the use of colored paper for insertions.

MEDICAID

MANAGEMENT INFORMATION SYSTEM

RECORD OF RECEIPT OF GENERAL DESIGN TRANSMITTALS

This form should be filed in front of the Medicaid Management Information System, General Systems Design, Volume I. When a transmittal is received, the following action should be taken:

1. Make the changes specified in the transmittal.

2. Post on this form the number and date of the transmittal and the initials or name of the person who made the changes.

3. Check the number of the transmittal against the previous number. Any missing transmittal should be requested from the Division of Medicaid Systems, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Transmittal No.	Date	Entered By	Transmittal No.	Date	Entered By	Transmittal No.	Date	Entered By

MEDICAID

MANAGEMENT INFORMATION SYSTEM

SECTION I

MODEL SYSTEM OVERVIEW

SECTION I

MODEL SYSTEM OVERVIEW

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I. MODEL SYSTEM OVERVIEW

A. BACKGROUND

Over the period of five fiscal years from 1966 through 1970, the Medicaid Program 1/ has expanded from six States at inception to the present total of forty-eight States and four Jurisdictions. The combined Federal-State expenditures for medical assistance for this same period rose rapidly from 1.7 billion to over 4.7 billion. It is estimated the expenditures for FY 1971 will total 5.9 billion, and by the end of FY 1972, 7 billion. 2/

Concern over rapidly rising Medicaid costs and inflation in the health field, led to the establishment of a Task Force on Medicaid and Related Programs in July 1969, to examine the deficiencies of the Medicaid and related programs and to make recommendations to the Secretary of Health, Education, and Welfare. These recommendations were submitted in an initial report on November 12, 1969, and in final on June 29, 1970. One result of these recommendations was the organization of a Division of Management Information and Payment Systems within the Medical Services Administration, Social and Rehabilitation Services, to develop and provide ongoing evaluation of Claims Payments and Management Information needs and systems.

The development and delivery of a Model System to each State has been acknowledged by the Federal Government as necessary to aid the States in meeting their responsibilities under the law. 3/ By providing this and other technical and financial support, it is expected the States will be better able to realize efficient and effective administration of the program, and that it will reduce program costs.

To achieve this end, and with the interest and cooperation of the States, the Division of Management Information and

---

1/ Enacted in 1965, under Title XIX of the Social Security Act, Medicaid is a Federal-State Medical Public Assistance Program, which at the option of the States, makes vendor payments to providers of Medical Services on behalf of recipients of cash maintenance payments and on behalf of other categories of people (the "medically indigent") who need help in meeting medical expenses.

2/ Budget of the U. S. Government, 1972, excluded State local payments not matchable by Federal funds.

3/ House Ways and Means Committee and Senate Finance Committee Reports on Amendments to the Social Security Act: HR #17550, 1970 and HR #1, 1971.

Payments Systems, Medical Services Administration, has developed a Model Management Information System for Title XIX Programs.

B. OBJECTIVE

The overall objective for the Model Management Information System is to improve the capability of the Title XIX State Agency to administer the Medicaid Program within its State. To accomplish this objective, emphasis has been placed on the development of a design to effectively process and control claims and to provide management with the necessary information for planning and control.

C. GENERAL DESIGN CONSIDERATIONS

1. Design Scope

The documentation material contained within the six sections that follow constitute the general or conceptual design of a Medicaid Management Information System for Title XIX. This General Systems Design is intended to provide the framework for the development of detailed systems and programming specifications preparatory to the implementation of the system.

The purpose of the General Systems Design is to establish and set forth the following design specifications:

a. Model System functional requirements.

b. Structure of the Model System.

c. Processing flow within the structure.

d. Clerical functions to support the processing flow.

e. Automatic data processing functions to support the processing flow.

f. Data element requirements and definitions.

g. Output requirements.

h. Input requirements.

i. Data file requirements.

2. General Design Usage

It is the policy of SRS to encourage each State and Jurisdiction to independently install all or a portion

of the Model Medicaid Management Information System depending upon individual circumstances and the need for improvement. In this regard, the General Systems Design presented in these volumes provides the basis for the preparation of detailed design specifications tailored to the particular requirements of an individual State.

It is recognized that the environment in which the Title XIX Program operates differs to a certain degree from State to State. It is also acknowledged that some States have specialized problems, unique unto themselves. However, it has been the goal of the system designers to develop, insofar as possible, a General Systems Design applicable to States large and small. It is anticipated that any special circumstances or unique problems that may exist can be provided for during the detailed design phase.

Quite often during the development of the General Systems Design it was necessary to specify a particular coding structure or select a particular approach from among a series of alternatives. Material of this nature, presented in the General Systems Design, should be viewed as the recommendation of SRS. For example, the series of data edits, validity tests, and reasonableness checks applied to claims input data as outlined in Section IV are considered essential for responsible claims processing. In a similar manner, the surveillance and utilization review reports contained in Section VI are representative of the type of information that should be provided and analyzed in the monitoring of utilization. SRS recommendations do not preclude the use of other approaches or methods as long as they satisfy the specifications of the Model System.

In an attempt to establish a degree of standardization, recommendations have also been provided as to specific coding structures for certain data elements. Data element definitions and structure recommendations are contained in the Appendix.

3. Modular Design Concept

In order to enhance the adaptability of the Model System to differing State environments and to facilitate implementation activities, a special effort was made during the design of the individual subsystems to logically group together the processes that concern the same or closely related functions. A group of such related processes that work in conjunction with each other to accomplish a specific function is termed a module. A module is normally comprised of a mixture of clerical

processing procedures and data processing operations working together to accomplish a specific function, but in some instances a module could be comprised exclusively of manual procedures or of only machine data processing operations.

As pointed out previously, each State or Jurisdiction is strongly encouraged to adopt the Model System, if not in whole, then in part, as individual circumstances dictate. If a State should require only certain portions of the Model System, the value of the modularity concept becomes particularly relevant. However, it is extremely important to recognize that very few modules are autonomous with the capability to function independently of any other module. To illustrate, the group of modules comprising the Surveillance and Utilization Review Subsystem might appear to be ideally suited to meet a particular State Agency's need in this area. However, adoption of only these modules from the Model System could well be the wrong decision if the data base is not available within the State Agency to support a Utilization Review System of this type. In such a situation, it is probably both necessary and desirable for the State Agency to also adopt the Claims Processing Subsystem to ensure establishment of the data base needed to conduct an effective utilization review program. The main point being that prior to the adoption of only select components from the Model System consideration should be given to such matters as: (1) special computer programs required to properly format data for input into the module and to format resulting output data for re-entry into the existing system, (2) conversion requirements to existing data files, and (3) content and validity of the data residing in present Medicaid files.

In summary, the Model Medicaid Management Information System has been developed first and foremost as an integrated information system designed to handle the basic functions of a Title XIX Program. Insofar as possible, efforts have been made in the General Systems Design not to preclude the extraction of various modules out of the total system to meet limited needs. However, it is strongly felt that more satisfactory results will be achieved when the Model System is installed in its entirety as an integrated unit.

4. Equipment Configuration

Of prime consideration in the development of any system are the computer hardware requirements necessary to support the system. To a certain degree, the computer capacity required and processing run times will be

dependent on the skills of the systems designers and on the proficiency of individual programmers. In general, the recommended computer configuration is a medium size computer with 100 million bytes of direct access mass storage, six tape drives, a card read/punch unit, a printer, and a communications controller capable of controlling relatively simple terminal devices. However, considerable improvement in operating efficiency will derive from the availability of additional direct access mass storage. States with particularly large claim volumes will require a larger configuration. Such States can also effectively use OCR (Optical Character Recognition) equipment for data entry. The usage of COM (Computer Output Microfilm) techniques is also highly recommended for States with moderate to heavy claim volumes.

D. ADOPTION OF THE MODEL SYSTEM

As stated at the beginning of this section, this document represents the General Systems Design for a Model Medicaid Management Information System. In essence, this General Systems Design provides the foundation for preparing a detailed design to satisfy the specific requirements in a particular State. The detailed design phase is essential whether the Model System is adopted in its entirety or a State adopts only select components of the Model System to its existing operation. Essential activities that should be accomplished preparatory to installation of any portion of the Model System include:

1. Organizational Analysis -- determination of the desirability of any changes within the Medicaid organization, such as lines of authority and areas of responsibility.

2. Operational Analysis -- determination of the requirement for any modification in present Medicaid Program policies, operating methods and procedures.

3. Personnel Requirements -- identification of any change in manpower levels and in manual functions performed.

4. Equipment Requirements -- identification of any changes required in the existing computer configurations or in supporting equipment.

5. Detailed System Specifications -- preparation of complete specifications on all computer programs, files, inputs, and clerical job procedures.

6. Implementation Planning -- development of a comprehensive plan for implementation of the system, to include a time-phased programming and installation schedule, a project test plan, manpower estimates, conversion requirements, and cost estimates.

7. Computer Programming -- performance of all coding, testing, and documentation of computer programs, including special conversion programs.

8. Systems Readiness -- performance of extensive tests of the overall system, parallel testing where feasible, user training, and all conversion activities possible prior to installation.

9. Systems Installation -- performance of final conversion activities and switchover to Model System.

E. MANAGEMENT NARRATIVES

The Model Medicaid Management Information System is divided into six functional areas or subsystems as follows:

1. Recipient Subsystem

2. Provider Subsystem

3. Claims Processing Subsystem

4. Reference File Subsystem

5. Surveillance and Utilization Review Subsystem

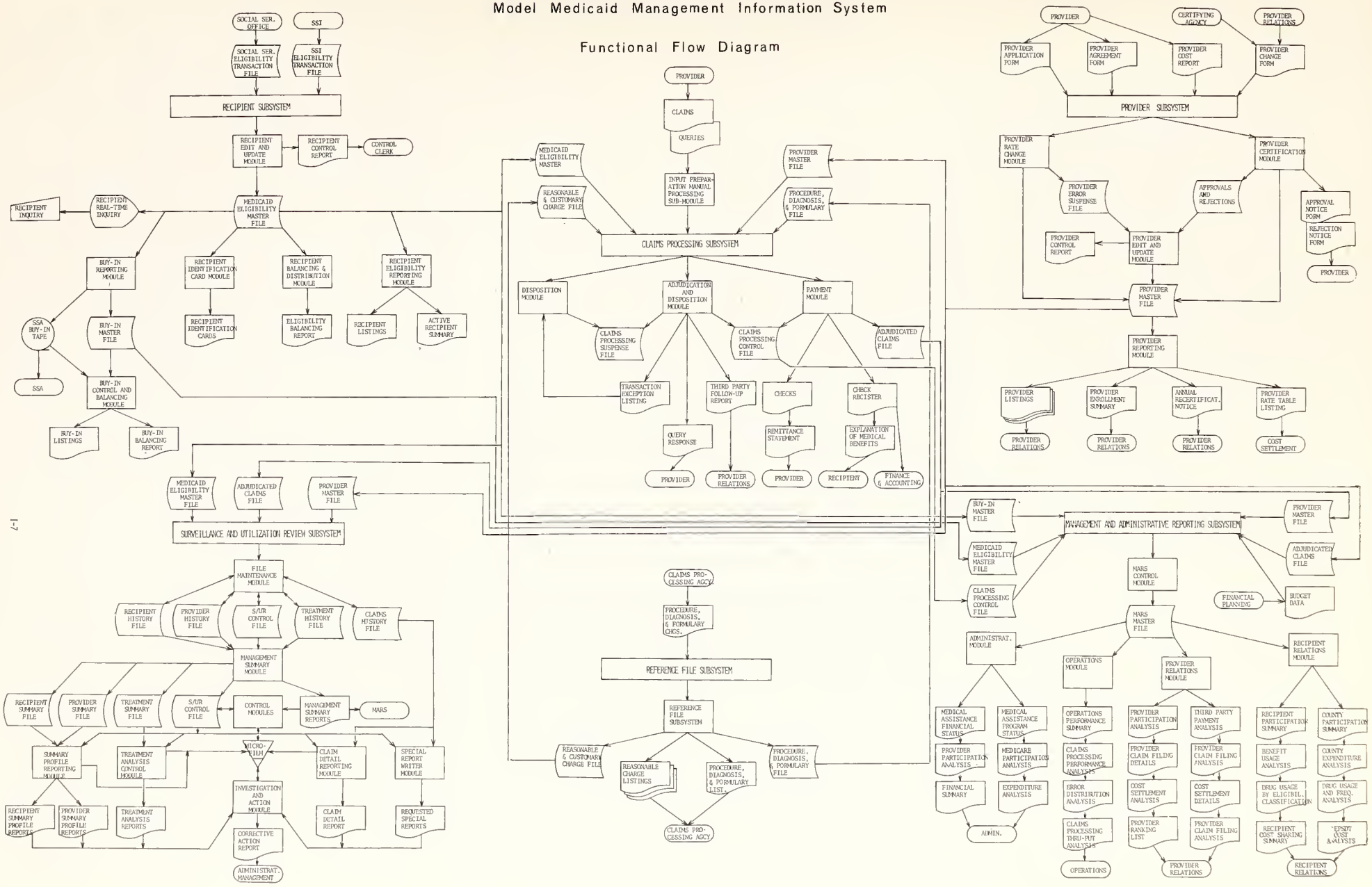
6. Management and Administrative Reporting Subsystem

The Recipient, Provider, Reference File, and Claims Processing Subsystems, in a sense, function as an integrated unit with the overall objective to process and pay each eligible provider for all valid claims on any eligible recipient. The Surveillance and Utilization Review Subsystem and the Management and Administrative Reporting Subsystem are basically concerned with data consolidation, organization, and presentation in a concise, meaningful manner that will enable management to effectively control their Title XIX Program.

Presented on the following page is the Model Medicaid Management Information System Functional Flow Diagram which provides a graphical presentation of the overall system flow. On subsequent pages, a summary description of each subsystem is provided to furnish an overview of the Model System in terms of scope, approach, and functions.

Model Medicaid Management Information System

Functional Flow Diagram



RECIPIENT SUBSYSTEM

The principal functions performed in the Recipient Subsystem are to:

a. Maintain identification of all recipients eligible for Medicaid.

b. Provide the mechanism for frequent and timely updates to all recipient eligibility records.

c. Exercise control over data pertaining to recipient eligibility, including Medicare Part B Buy-In processing.

d. Provide a computer file of all eligible recipients to support claims processing, surveillance and utilization review activities, and management reporting.

Upon certification of recipient eligibility for Medicaid benefits and upon any subsequent change in this eligibility, the State Social Service Department and the Bureau of Supplemental Security Income (SSI) within the Social Security Administration are charged with transmittal of timely and adequate eligibility data to the Single State Agency. In many States the process is facilitated by the fact that the Department of Social Services and the Single State Agency are one and the same. In the State Agency operation the Recipient Subsystem serves as the point of entry for all eligibility transaction transmittals. These transactions are immediately subjected to a series of computer edits to verify the completeness and validity of each item of data. Transactions containing erroneous data are suspended by the computer and not permitted to update the Medicaid Eligibility Master File. All transaction errors remain under computer control and are not released from suspense until appropriate corrective action is taken. By means of this process, the integrity of the Medicaid Eligibility Master File is insured at all times.

As a further measure to verify that complete agreement exists between the Medicaid Eligibility Master File maintained by the Single State Agency and the corresponding SSI File and State Social Services File of Medicaid eligibles, a periodic balancing of the files is recommended. This procedure is particularly important when the Social Services Department is not the Single State Agency.

In addition to maintenance of the master eligibility file, the Recipient Subsystem maintains control of the Title XVIII Part B Buy-In process. Each month potential buy-in recipients are identified and appropriate records transmitted to the Social Security Administration (SSA). Correspondingly, Buy-In responses are received from SSA, monthly billing data from SSA is processed, and the Medicaid Eligibility Master File is updated to reflect individual recipient buy-in status.

The final major responsibility of the Recipient Subsystem is the issuance of identification cards on a monthly basis to provide the recipient with proof of eligibility. If possible, the printing of identification cards should be done in conjunction with the issuance of welfare assistance checks.

PROVIDER SUBSYSTEM

The principal functions performed in the Provider Subsystem are to:

a. Process and enroll providers in the Medicaid Program upon their agreement to comply with Title XIX rules and regulations.

b. Ensure that only qualified providers are permitted to render service.

c. Create and maintain a computer file of all eligible providers to support claim processing, surveillance and utilization review activities, and management reporting.

Applications for enrollment as qualified Medicaid providers are submitted to the Single State Agency. Application data is immediately entered into the system and computer control is maintained over all applications until a final determination of eligibility is made. The provider application is evaluated against Medicaid standards and the subsequent approval or rejection issued through the computer.

The provider application furnishes the basic data needed for creation of a Provider Master File record. All original data items and any subsequent changes are completely edited, prior to permitting updates to this file, to ensure that no erroneous data is introduced. All transactions in error are suspended by the computer pending corrective action.

The updating of the Provider Master File with individual provider and institutional provider rates is also performed within this subsystem. Institutional rates are updated whenever the cost audit and settlement with a particular provider indicates the need for an adjustment. Reasonable and customary charge ranges which apply to more than a single provider are handled through the Reference File Subsystem.

CLAIMS PROCESSING SUBSYSTEM

The principal functions performed in the Claims Processing Subsystem are to:

a. Ensure that all claims and related transactions are accurately input into the system at the earliest possible time.

b. Establish strict system controls to ensure that all transactions are processed completely and promptly and that all claim discrepancies are resolved expeditiously.

c. Verify the eligibility of both the recipient and the provider and the validity of the claim information submitted.

d. Ensure that correct payment is made to providers on a timely basis.

e. Create a computer file of adjudicated claims to support surveillance and utilization review activities and management reporting.

After furnishing services to recipients, each provider submits requests for payment to the Single State Agency or its designated fiscal agent by means of a claim document or equivalent machine-readable input. The payment agency, upon receipt of claim documents, immediately assigns a control number to each document, microfilms all documents, screens documents for suitability for machine processing, and converts acceptable documents to machine-readable format. The microfilm process is optional depending upon the document volume involved.

Each claim entered into the computer system undergoes a series of validation steps including (1) editing of claim data, (2) checks for compatibility of procedures and diagnoses, (3) verification that the provider was both authorized to provide the service and eligible at the time of service, (4) verification that the recipient was eligible for the service at the time it was rendered, (5) checks for the possibility of third party liability, and (6) ensures that the claim does not duplicate nor conflict with a previously processed claim.

Claims unable to pass the validation steps listed above are suspended by the computer to await corrective action. Computer prepared exception listings and source document microfilm files are made available to claims correction clerks and various medical review personnel as required. If on-line terminal equipment is available, corrective actions are taken by entering them through the terminal. If such equipment is not available, the appropriate corrective action is indicated directly on the computer listings, which are then used to input error corrections into the system. Error claims thus corrected are released from suspense and recycled through the claim validation routines.

Claims passing the validation routines are accumulated until the next payment cycle. At that time payment instruments with their

supporting documentation are produced and historical records are generated for use by the Surveillance and Utilization Review Subsystem and the Management and Administrative Reporting Subsystem.

In addition to the process of validating and paying claims, the Claims Processing Subsystem provides responses to queries concerning claim and recipient status and also generates statements of medical benefits received for all recipients.

REFERENCE FILE SUBSYSTEM

The principal functions performed in the Reference File Subsystem are to:

a. Provide a generalized update facility for various reference files used in claims processing.

b. Provide Medicaid practitioner usual and customary charge data and incorporate Medicare usual and customary charges into the Medicaid system.

c. Generate various listings of claims suspended because of error conditions.

All requests for listings from the changes to the medical procedures, drug formulary, and medical diagnosis computer files are processed through the Reference File Subsystem. All additions, deletions, and changes to these files are subjected to error detection edits and cannot update their respective files if errors exist. Complete audit trails are produced as a byproduct of each update.

A second function of the Reference File Subsystem is to provide the data to conduct periodic analysis of historical practitioner claim charges. Based on this analysis, updates are made to the Reasonable and Customary Charge File. Reasonable charge listings are organized by area and for individual practitioners.

The final major function under control of this subsystem is the generation of various reports based on data contained in the file of claims suspended due to error conditions. These reports include an aged listing of suspense claims, a list of all claims suspended due to a particular error condition, and a list of all suspended claims for a given provider.

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

The principal functions performed in the Surveillance and Utilization Review Subsystem are to:

a. Develop a comprehensive statistical profile of health care delivery and utilization patterns.

b. Reveal suspected instances of fraud or abuse of the Medicaid Program by individual providers and recipients.

c. Provide information indicating the existence of any potential defects in the level of care or quality of service provided under the Medicaid Program.

The principal source of input for the Surveillance and Utilization Review Subsystem is in the output file of adjudicated claims from the Claims Processing Subsystem. The master files from the Provider Subsystem and Recipient Subsystem are used to supply certain demographic and identification data on individual providers and recipients.

All participants, providers and recipients, are classifed into homogeneous groupings according to their particular characteristics. A statistical profile is developed of each such group and also of each individual participant. Individual participant profiles are then measured against the appropriate group profile and all participants deviating significantly from this group norm are displayed for review. The participants which are excepted are then investigated in detail to confirm if misutilization has, in fact, occurred. Appropriate corrective action is initiated against proven misutilizers in accordance with the nature and severity of the improper activity or practice that was detected.

The computer system accomplishes all operations required to identify the exceptions to the norms of participant performance. To assist in the subsequent investigative process of confirming misutilization, the computer system provides access to all substantiating claim data. The user has the facility to select and print only the claim data that is of potential value in making a determination as to misutilization.

MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

The principal functions of the Management and Administrative Reporting Subsystem are to:

a. Furnish the Single State Agency with information to support the management review, evaluation, and decision making processes.

b. Provide management with financial data for proper fiscal planning and control.

c. Provide management with information to assist in the development of improved medical assistance policy and regulations.

d. Monitor the progress of claims processing operations, including the status of provider payments.

e. Analyze provider performance in terms of the extent and adequacy of participation.

f. Analyze recipient participation in terms of the nature and extent of services received.

g. Provide the necessary data to support Federal reporting requirements.

The information appearing on the reports generated by the Management and Administrative Reporting Subsystem is derived from basic data collected in the Recipient, Provider, and Claims Processing Subsystems. On a routine basis, key data is extracted from computer files in these subsystems and consolidated into summary history files. All reports produced directly by this subsystem are from information maintained on the summary history files.

The reports produced by the Management and Administrative Reporting Subsystem are designed to satisfy information needs in four areas: (1) administration, (2) operations, (3) provider relations, and (4) recipient relations. In order to provide the variation in degree of detail that is required at different levels of operation within the Medicaid organization, each report is designed to display data to the level of detail consistent with the intended purpose of the report. Four reporting levels are defined varying from concise, summarization reports at the top level to detailed transaction listings at the lowest level. This lowest level of reporting is comprised almost exclusively of reports provided to support clerical functions. Reports intended to support clerical operations are produced in the other subsystems, while the Management and Administrative Reporting Subsystem confines itself to the preparation of various summary, evaluation, and analysis reports for management.

F. MODEL SYSTEM HIGHLIGHTS

The following itemized lists are furnished to provide the reader with a capsule view of key features in the Model System and, thereby, an insight into the general philosophy of the design in terms of anticipated benefits to the user.

GENERAL

1. Emphasis on a high degree of automation.

2. Modular systems design approach to facilitate adaptability and implementation in differing environments.

3. Inclusion of the clerical processing steps required for support of the computer processing.

4. Early establishment of control over all transactions.

5. Provision for furnishing complete audit trails for all transactions.

6. Flexibility to meet changing requirements and innovations in health care services.

7. Sufficient flexibility to meet the requirements of States of all sizes.

8. Capability for time-phased implementation.

PROVIDER

1. Existence of computer control over provider application, approval, and re-certification activities.

2. Recommended usage of unique provider numbers with a self-checking capability.

3. Provision to handle providers furnishing multiple categories of service.

4. Automated process for handling provider credit balances.

5. Creation of an extensive provider data base to support claims processing, management reporting, and surveillance and utilization review.

6. Provision to handle multiple periods of provider ineligibility.

7. Automated provider acceptance and rejection notification.

RECIPIENT

1. Existence of computer control over all recipient eligibility transactions.

2. Capacity for timely updating of Medicaid eligibility files.

3. Provision to handle recipients with intermittent periods of ineligibility.

4. Provision to handle medically needy spend-down.

5. Facility for issuance of monthly identification cards for positive identification of recipient eligibility.

6. Provision for periodic matching and balancing of Medicaid eligibility files against social services and SSI master files to insure the integrity of all recipient records.

7. Computer control over the Title XVIII Part B Buy-In processes.

8. Creation of an extensive recipient data base to support claims processing, management reporting, and surveillance and utilization review.

CLAIMS PROCESSING

1. Capability to identify the status of a claim from its points of entry into the system until eventual payment or denial.

2. Comprehensive claim validation processing including duplicate claim analysis, identification of suspected third party involvement, recipient over-utilization checks, reasonableness edits on services provided, and reasonable charge verification.

3. Capability to check, to the extent possible, for all error conditions on a single pass through the data validation and verification routines.

4. Control measures to ensure prompt attention to the correction of claims suspended for error conditions, and correction of the causes of these error conditions.

5. Capacity to automatically notify a provider of the status of any claim in a suspended status.

6. Facility to print an Explanation of Medical Benefits for all recipients receiving services.

7. Automated responses to provider requests for recipient information of a non-confidential nature.

8. Flexibility with regard to the method of determining payment for each type of provider.

9. Recommended method of Medicare crossover processing to minimize document handling and payment delays.

SURVEILLANCE AND UTILIZATION REVIEW

1. Development of a comprehensive profile of health care being delivered through Medicaid.

2. Identification of potential defects in the quality of service and level of care provided.

3. Provision for classification of providers into homogeneous groups to perform exception processing.

4. Development of individual provider and recipient utilization profiles.

5. Determination of norms of care for homogeneous provider and recipient groups.

6. An extensive exception processing capability to automatically identify potential cases of provider or recipient misutilization.

7. Identification of instances of provider or recipient fraud.

8. Facility to substantiate all exceptions with supporting detail data when requested.

9. High degree of flexibility with respect to the selection of the content of individual reports.

10. Extensive compilation and maintenance of trend data.

11. Availability of frequency distributions and standard deviations for provider and recipient to facilitate statistical analysis of norms of care.

12. Provision for a general purpose report writer to satisfy specialized user information needs.

MANAGEMENT AND ADMINISTRATIVE REPORTING

1. Reports designed to meet specific requirements at each level of management responsible for Medicaid operations.

2. Extensive use in reports of trend data, comparative historical data, indices, and data projections.

3. Reports specifically formulated to support the decision process for the Medicaid Program.

4. Financial management reports to analyze expenditures, to exercise budget control, and to support fiscal planning.

5. Provider performance reports to gauge provider participation, to identify claim filing delays and filing errors, and to measure effectiveness in third party recoveries.

6. Recipient participation reports to analyze the nature and extent of services obtained by aid category and by geographic location.

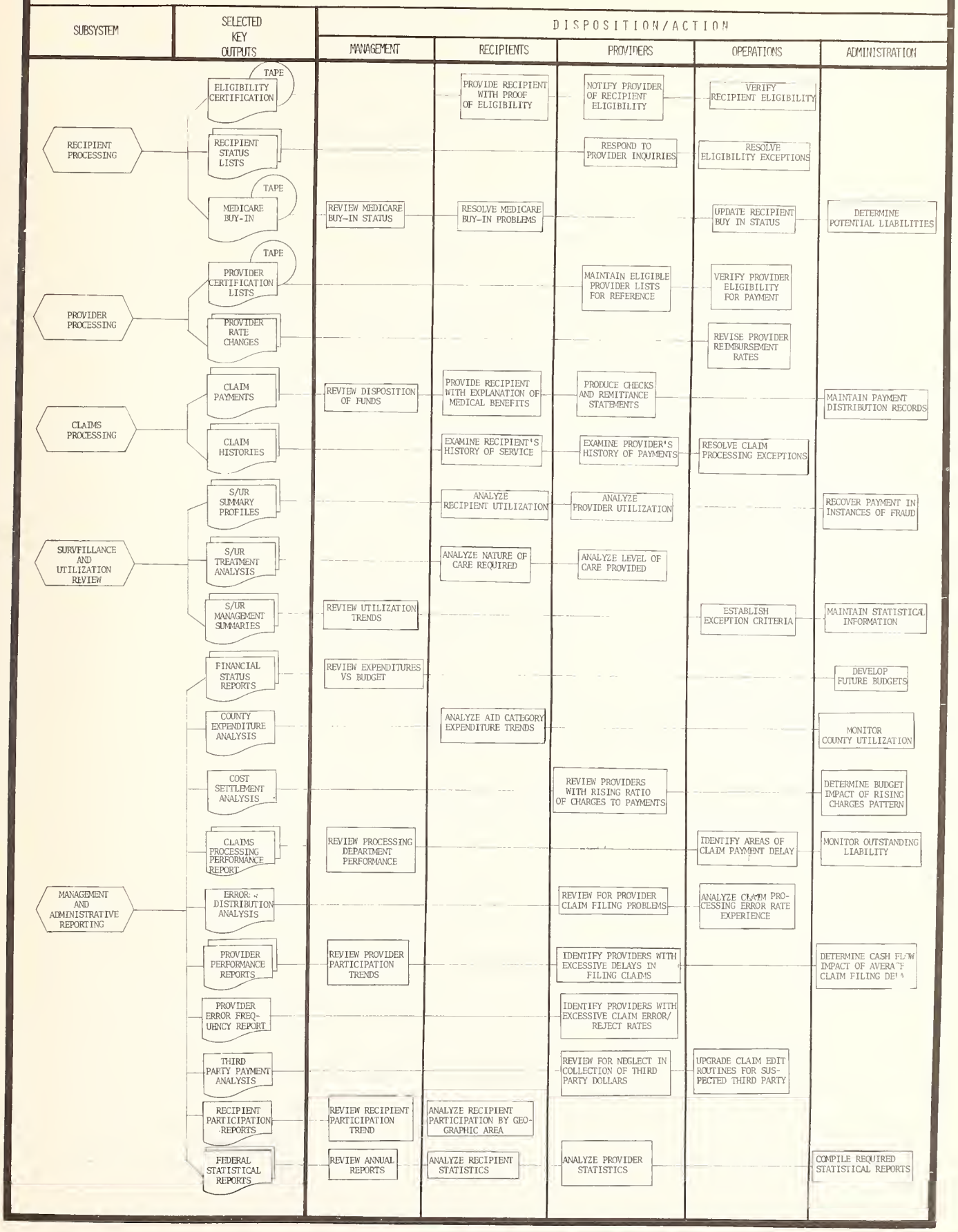
7. Operation monitoring reports to review processing thruput rates and to analyze the nature and magnitude of processing errors.

8. Establishment of the data base necessary to satisfy Federal Title XIX reporting requirements.

G. MODEL SYSTEM KEY INFORMATION FLOW

The diagram on the following page shows selected reports from the Model System, indicating the subsystem producing each report and the primary function or usage of that report.

Model System Key Information Flow



MEDICAID

MANAGEMENT INFORMATION SYSTEM

SECTION II

RECIPIENT SUBSYSTEM

SECTION II

RECIPIENT SUBSYSTEM

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II. RECIPIENT SUBSYSTEM

A. SUBSYSTEM SUMMARY

1. Objectives

The Recipient Subsystem has been developed to accomplish the following primary objectives:

a. Maintain identification of all applicants eligible for Medicaid benefits.

b. Provide timely updating of the Medicaid Eligibility Master File to include new recipients and all changes to existing recipient records.

c. Maintain positive control over all data pertaining to Medicaid recipient eligibility.

d. Build and maintain a computer file of recipient data to be used for forms processing, administrative reporting, and surveillance and utilization review.

e. Distribute eligibility data to other processing agencies, if a requirement exists.

f. Maintain control over the Medicare Part B Buy-In processing for eligible recipients.

2. General Description

The Recipient Subsystem has been divided into seven modules for the purpose of this presentation. The seven modules are as follows:

a. Edit and Update Module

b. Real Time Inquiry Module

c. Identification Card Module

d. Eligibility Reporting Module

e. Balancing and Distribution Module

f. Buy-In Reporting Module

g. Buy-In Control and Balancing Module

These seven modules represent seven important functional areas within the Recipient Subsystem. They do not necessarily reflect the most logical grouping of activities from a data processing or a manual processing point of view. They do, however, present a logical processing flow for each of the seven functional areas in this subsystem. The modules also reflect various options within this subsystem which a State may need to include in its Medicaid system, depending on the structure of the Medicaid-Social Services relationship in that State and the role of SSI in determining Medicaid eligibility for the State.

The Edit and Update Module receives eligibility transactions from the State Social Services (welfare) Department and SSI, edits data for completeness and validity, and updates the Medicaid Eligibility Master File on the computer. This module also processes change data and corrections generated within the Single State Agency. Erroneous data is identified, corrected, and controlled within this module.

The Real Time Inquiry Module is an optional module for those States which have large capacity direct access storage available with their computer system and can justify the need for rapid inquiry concerning recipient eligibility. This module processes inquiries on a real-time basis and responds with recipient eligibility data via a video display tube or other terminal equipment.

The Identification Card module is an optional module for the Medicaid System because it is hopefully already a part of the State Social Services Activity, probably as a by-product of the printing of public assistance checks or as a separate function for non-money payment recipients and SSI recipients. However, for those States where this function is not being done by Social Services, it is strongly recommended that this module be a part of the Medicaid System. This module regularly prints an identification card for each Medicaid recipient. This card is used to identify an eligible Medicaid recipient to a provider with regard to his benefits and to provide the necessary recipient data for filling out a provider claim form. The Identification Card Module can also print replacement identification cards upon request if the State desires this capability.

The Eligibility Reporting Module prints lists of eligible recipients by name and by identification number. These lists serve as the means for answering recipient inquiries if the Real Time Inquiry Module is not selected or as backup for the Real Time Inquiry Module if that module is chosen.

The Balancing and Distribution Module performs two functions, each of which is optional. The first function is to compare and balance the Medicaid eligibility file periodically against the Social Services and SSI eligibility files to ensure that the files agree. This is an important control function and should be done in the Medicaid System if it is not already being done in the Social Services System. The second function is only required for States that elect to have some outside agency(s) handle part of their Medicaid processing. This module then creates a copy (or copies) of the Medicaid eligibility file for distribution to the other processing agency(s).

The Buy-In Reporting Module is designed primarily for States who do not elect the Social Security Administration's automatic accretion process for their State Buy-In Plan and thus must identify potential buy-in recipients. However, the Buy-In Reporting Module can be adapted to handle the SSA Automatic Accretion Method. This module performs the functions of identifying the potential buy-in recipients each month, sending records on these recipients to SSA, and keeping records for these recipients on the Buy-In Master File for further processing by the Buy-In Control and Balancing Module. The enrollment and payment of Part A premiums, for those recipients who were previously eligible for Part B only, could be handled in a manner similar to the Part B Buy-In process, but is not addressed specifically in this subsystem due to the small number of recipients who are eligible and the optional nature of the States' coverage of these recipients.

The Buy-In Control and Balancing Module processes buy-in changes and corrections generated within the Single State Agency, processes records of potential buy-in recipients from SSA if the automatic accretion process is used, processes buy-in response data from SSA if the automatic accretion process is used, and processes monthly billing data from SSA for active buy-in recipients. All of these transactions are edited, and valid transactions update the Buy-In Master File. This module detects incomplete or erroneous data and provides the means for correcting this data. This module also provides the mechanism for a coordination of efforts by the State and local Social Services departments, the Medicaid agency, and the Social Security Administration for resolving any discrepancies between Social Services, Medicaid records and SSA records.

To summarize, the Recipient Subsystem in its entirety is responsible for:

a. Identifying all Medicaid eligibles.

b. Editing all transactions affecting recipient eligibility for completeness and validity.

c. Correcting erroneous data.

d. Controlling all data relating to recipients.

e. Updating recipient eligibility files to reflect the most current status of each recipient.

f. Maintaining buy-in data on eligible recipients.

g. Reporting potential buy-in recipients as they become eligible.

h. Controlling buy-in premium payments.

i. Generating buy-in transaction data to be sent to SSA.

j. Receiving buy-in transaction data from SSA and reconciliation of unmatched items.

k. Responding to inquiries concerning recipient eligibility.

l. Printing recipient identification cards.

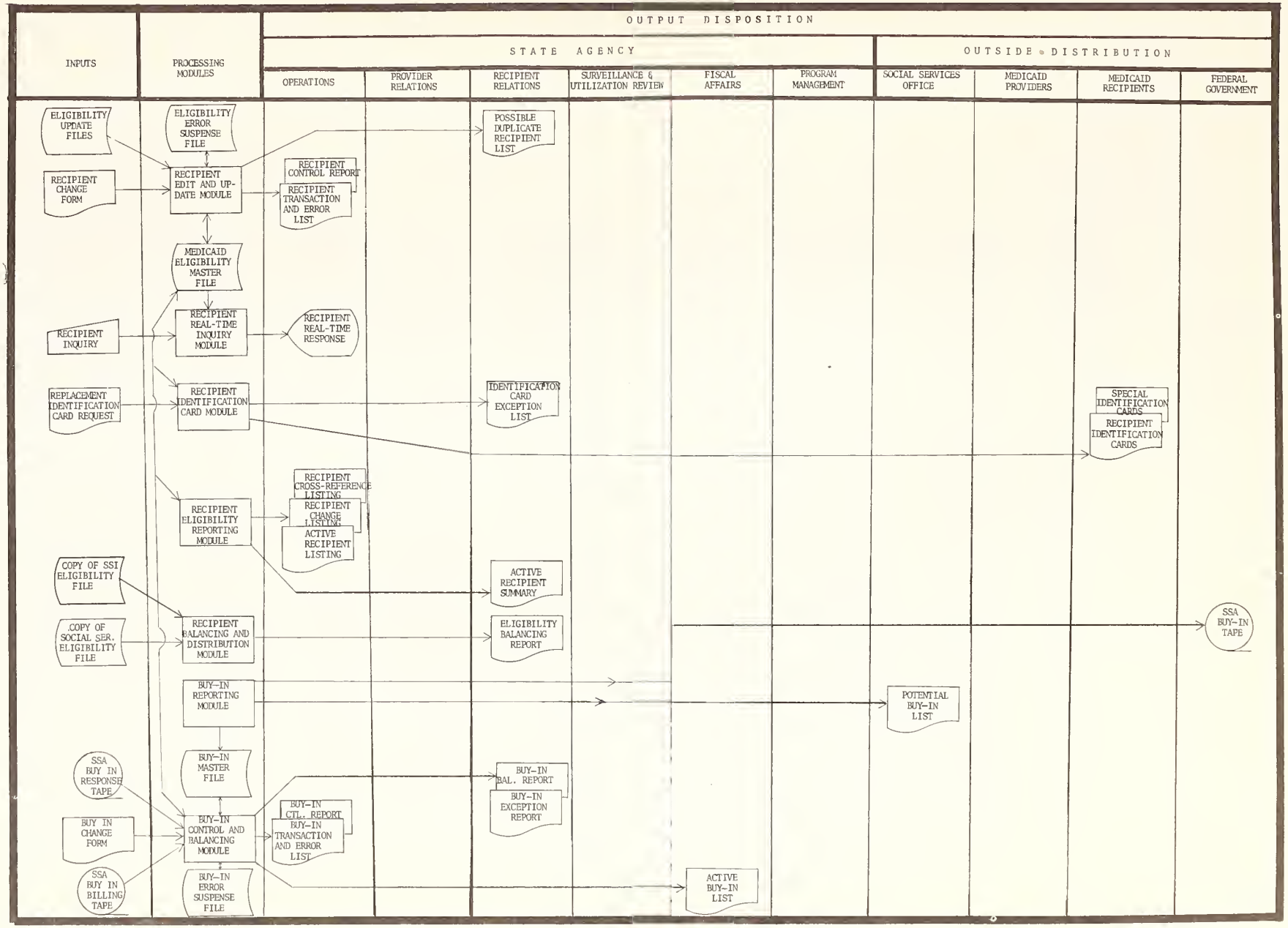
m. Reconciling periodically the Social Services, SSI, and Medicaid eligibility files.

The updating of the Medicaid Eligibility Master File and the Buy-In Master File will be daily (for each day that transactions are available). All reports except those used for error correction and control (or for listing daily transactions) are produced on a monthly basis. Replacement identification cards are produced on a daily basis, if requested.

3. Information Flow Diagram

The Recipient Subsystem Information Flow Diagram found on the following page provides an overview of the Recipient Subsystem. The diagram shows the interrelationships of the processing modules and identifies the principal users of each module output. A description of the processing steps and flow of information within the subsystem is presented in detail in Section II-C.

RECIPIENT SUBSYSTEM - INFORMATION FLOW DIAGRAM



B. DESIGN ELEMENTS

1. Constraints and Assumptions

The Recipient Subsystem was designed based on the following constraints and assumptions:

a. The public assistance payment function and the Medicaid function are to be considered as separate entities even through they may be performed by the same State agency.

b. The certification and recertification of public assistance recipients for assistance payments and Medicaid eligibility is a Social Services and SSI function as opposed to a Medicaid function.

c. Social Services data will be kept separate from Medicaid eligibility data for ease of processing.

d. A provision for handling eligible recipients of the Crippled Childrens Program (Title V) is not specifically included in the scope of the Model Medicaid System but the design of the Recipient Subsystem does not preclude addition of this function during detailed design.

e. A unique number will be assigned to each recipient and that number will remain with that recipient even if the recipient has a change of county or aid category.

f. Recipients can become eligible at any time during a month but will become ineligible only at the end of a month.

g. An individual recipient's eligibility may change on a month to month basis (eligible one month, not eligible the next, eligible again, etc.).

h. A recipient eligible for buy-in must have attained age 65 or, not having attained age 65, be disabled and entitled to monthly disability benefits for at least 24 consecutive months.

i. A recipient is not considered bought-in until SSA verifies the buy-in.

j. All necessary Medicaid eligibility certification data on recipients are collected in the Social Services and SSI Systems and update transactions are forwarded to the Single State Agency in a timely manner.

k. It is assumed that an organization exists at the Single State Agency to provide coordination with the Social Services Department and SSA to resolve differences with respect to recipient eligibility.

2. Design Considerations

During the development of the general design of the Recipient Subsystem, a number of design decisions were required in areas where more than one approach was feasible. An evaluation was conducted on the advantages and drawbacks connected with each alternative identified prior to adoption of a particular solution or approach for the Model System. A discussion that follows summarizes for each major item of consideration the alternatives explored and the resulting Model System recommendation.

a. Assignment of Recipient Identification Numbers

The highly mechanized nature of the Model System dictates that a recipient identification number be assigned to each recipient. To ensure the proper payment of claims for eligible recipients and to maintain a claims history for individual recipients for surveillance and utilization review, a unique recipient number is required. Therefore, a recipient identification number for a deceased recipient must not be reused for another recipient, at least for the period of time covered by utilization review. Likewise, a recipient should not be assigned more than one number, even if his county of residence changes or his aid category changes.

Any State which already has a unique number for recipients (whether it is the Social Services case number or some other number) can use their existing numbers for the Model System. For those States which do not have a unique number of recipients the following alternatives exist:

(1) Alter the existing number to make it unique.

(2) Provide a cross-reference of some kind so that all numbers for a single recipient can be tied together.

(3) Use the recipient Social Security Number if it is currently available.

(4) Establish a new number for the use of Medicaid recipients only.

Due to the large number of Medicaid recipients in each State, the changing of all recipient identification numbers is a formidable task. Fortunately, the computer can be of assistance in certain cases. In certain rare instances an existing recipient number can be made unique by the addition of certain other digits. However, it is unlikely that this alternative would be possible for many States.

For States that assign recipient numbers (case numbers) on a county basis but assign a new number when a recipient changes his county of residence, it is possible to set up a cross-reference to relate the two numbers to the same individual. It is also possible to convert to a numbering scheme which is based on original county of residence and original aid category as shown on the Data Element Definition Sheet for the Recipient Identification Number in the Appendix to this design document. Since a cross-reference can be time consuming and difficult to use, this approach should be avoided if possible.

The use of the recipient's Social Security Number for Medicaid identification would be very useful if all recipients had a Social Security Number. At the present time small children who are eligible for Medicaid rarely have Social Security Numbers. The time lag that presently exists in receiving a Social Security Number would definitely have an adverse effect on the functioning of the Medicaid Claims Payment System (for example, in providing care to a new born child). Some States assign pseudo-numbers to individuals who don't have Social Security Numbers while waiting for a Social Security Number to be obtained. This

method also has several disadvantages caused by checking to make certain that a Social Security Number does eventually get assigned and then cross-referencing the pseudo-number to to the real Social Security Number.

Also, some Medicaid recipients have more than one Social Security Number so policing the use of these numbers would be difficult. Until Social Security Numbers are mandated for everyone, the case-oriented welfare recipient number still has many advantages for Medicaid use, especially in AFDC cases which account for the majority of Medicaid processing.

The establishment of a new number for Medicaid processing may well be the only alternative available for a few States. This number could be assigned and controlled by the computer. If at all possible, a check digit should be included as part of the Recipient Identification Number.

b. Determination of Eligibility for Certain Medically Needy Individuals

The certification of eligibility for medically needy individuals is a Social Services function. However, in some states a unique situation arises because of a requirement for certain recipients to pay for a given amount of medical services before they become eligible for Medicaid. In certain circumstances a State may also elect a lower eligibility standard for Medicaid than that required for SSI eligibility, thereby necessitating a spend-down process for certain SSI recipients. This spend-down amount is, in effect, a recipient deductible amount as far as Medicaid claims processing is concerned. A spend-down amount could be carried in the recipient's record and would be reduced by the amount of claims paid by the recipient until the spend-down amount equals zero. Then the recipient's claims would be paid by Medicaid.

However, because of the cumbersome paperwork involved with that approach and because the recipient is not technically eligible for Medicaid until he has spent down to the desired level, the spend-down processing is considered a Social Services function and is not included in this Model Design. However, if a State

determines that the Medicaid system is the only logical entity to calculate and record the spend-down, the Model System can be modified during detail design to maintain spend-down amounts.

A satisfactory alternate method might be to require the recipient to keep track of his own spend-down. When the recipient determines that he has reached or exceeded his spend-down, he takes a copy of his paid bills to his local Social Services office where his eligibility for Medicaid coverage is then established.

c. Recipient Cost Sharing

Effective April 15, 1974, a State whose Medicaid Program encompasses the medically needy at its option can provide through its State Plan that an enrollment fee, premium, or similar charge be imposed with respect to the medically needy. The amount of this premium shall be related to the total gross income of each family as follows:

(i) A minimum charge equivalent to $1.00 per month can be imposed on each 1 or 2 person family with monthly gross income of $150 or less, on each 3 or 4 person family with monthly gross income of $300 or less, and on each family of 5 or more persons with monthly gross income of $350 or less. An appropriately higher charge must be imposed on each family with higher income.

(ii) Income-related charges above the minimum shall not exceed amounts equivalent to the monthly charges found in the following table:

GROSS FAMILY INCOME (per month)	MAXIMUM MONTHLY PREMIUM Family Size		
	1 or 2	3 or 4	5 or more
$150 or less	$ 1	$ 1	$ 1
151 - 200	2	1	1
201 - 250	3	1	1
251 - 300	4	1	1
301 - 350	5	2	1
351 - 400	6	3	2

GROSS FAMILY INCOME (per month)	MAXIMUM MONTHLY PREMIUM Family Size 1 or 2	3 or 4	5 or more
$401 - 450	$ 7	$ 4	$ 3
451 - 500	8	5	4
501 - 550	9	6	5
551 - 600	10	7	6
601 - 650	11	8	7
651 - 700	12	9	8
701 - 750	13	10	9
751 - 800	14	11	10
801 - 850	15	12	11
851 - 900	16	13	12
901 - 950	17	14	13
951 - 1000	18	15	14
More than $1000	19	16	15

For the categorically needy, the basic Medicaid services (inpatient and outpatient hospital services, other laboratory and x-ray services, skilled nursing home services, early and periodic screening diagnosis and treatment of persons under 21, family planning services, physician services, and home health care services) must be provided by a State and are not subject to recipient cost sharing. Cost sharing, however, may be imposed on any Medicaid services other than the basic services listed above and for all services to the medically needy, according to the following instructions:

(i) for non-institutional services, copayments will be limited as follows:

State Payment for the Service	Maximum Copayment Chargeable
$10 or less	$ .50
$11 to $25	$1.00
$26 to $50	$2.00
$51 or more	$3.00

(ii) for non-institutional services, deductibles must not exceed $2.00 per month for the period of eligibility.

(iii) for non-institutional services, coinsurance rates will be limited to five percent of the State's payment for each service furnished.

(iv) for institutional services, the maximum deductible, coinsurance or copayment charge will be limited to fifty percent of the State's payment for the first day of care.

(v) copayments may be applied to a State's average or typical payment for service rather than computing a copayment for each individual service.

The collection of a cost sharing premium for the medically needy is tied very closely to the spend-down process and the eligibility certification of medically needy recipients. For this reason, the premium amount could best be collected by the State Social Service Agency through a manual or automated system and charged back to Medicaid. This method is therefore recommended.

The collection of optional copayments, deductibles, and coinsurance (for medically needy and categorically needy recipients) can best be performed by the Claims Processing Adjudication Module. A discussion of this operation appears in that section.

d. Eligibility Periods

A recipient's income may fluctuate from month to month over such a range that his eligibility for Medicaid may change from month to month. The Model System has allowed for multiple eligibility periods for each recipient. This allows the retroactive payment of claims for earlier time periods. A recipient record is therefore not deleted from the Medicaid Eligibility Master File just because a recipient becomes ineligible.

e. Third Party Liability

Since Medicaid payments are to be made only after all other resources are exhausted,

it is imperative that third party liability be identified when it exists. The Model System approaches the third party liability area from two sides. The provider is required to indicate on the claims form the existence of third party liability. However, the provider is not always aware of the existence of a third party coverage.

A more effective way of controlling third party liability is to have the Social Services or SSI case worker determine the existence of a third party liability and code a third party indicator on the public assistance application or approval form for later transmittal to the Medicaid System.

This technique is often very effective because the case worker detects health insurance premiums or other indications of third party coverage when preparing the recipient's assistance. This approach requires close coordination between Social Services, SSI, and Medicaid to be effective.

f. Buy-In Problems

The number of design considerations associated with the buy-in function are too numerous to list individually, but in general the areas of concern are identifying eligible recipients, conversion of data files to correspond with SSA, and reconciliation of differences between Social Services, Medicaid, and SSA data. Some of the complicating factors associated with the buy-in are as follows:

(1) An individual may already have enrolled or be in the process of trying to enroll himself while the State is trying to enroll him.

(2) Non-money payment recipients are made eligible one month later than money payment recipients.

(3) A potential buy-in recipient may be held in a pending status while efforts are made at either SSA or the State to resolve differences in data items.

(4) Recipients are potentially eligible for buy-in but they refuse to establish eligibility with the SSA by getting a Social Security Claim Number.

(5) Disputes sometimes arise where more than one State claims an eligible recipient for buy-in.

(6) Retroactive accretions are possible along with retroactive billings of premium payments.

(7) Deletions from the buy-in program may be initiated by either the State or by SSA.

There are two principles for dealing with the numerous buy-in problems. The first is to install an effective system of handling all buy-in transactions. This approach is a part of the Model System design. The second principle is to establish good communications and to promote a spirit of cooperation between all levels of the SSA, Medicaid, and Social Services organizations. The only way to have an efficient buy-in program is to adopt both principles listed above.

g. Recipient Identification Cards

In order for a provider to properly fill out a claim form he must know the recipient's identification number. The use of a Recipient Identification Card, that the recipient can carry with him to the place of service, provides all of the information the provider needs to properly submit a claim and reasonably verify the eligibility of the recipient.

A permanent identification card is a possible approach. Because of the discussion above concerning multiple eligibility periods, a permanent card would have to be issued, called in, and reissued on a month by month basis or else the card would not truly reflect the actual eligibility of the recipient. It is possible to have a permanent identification card to supply necessary data to the provider and also require a real time inquiry into Medicaid computer to determine eligibility, but this approach would require a computer

on-line 24 hours a day, seven days a week. It is virtually impossible to cost-justify such an approach.

A replaceable monthly identification card is the alternative recommended for the Model System. The suggested approach is to print the identification cards (at least for money payment recipients) with the monthly assistance checks in the Social Services System. This eliminates duplicate mailings to recipients.

If the identification card cannot be printed in the Social Services System, they can be printed from the Medicaid Eligibility Master File in the Model Medicaid System.

A further modification of the monthly identification card approach is to attach preprinted pressure sensitive identification labels to the identification card for the use of providers. A provider can remove one of these labels from the identification card and attach it to the claim form. This reduces the amount of data which must be recorded on the claim form and minimizes the chance for error due to incorrectly copying the recipient data. This approach could easily be added to the Model System during detail design. This approach also has some disadvantages caused by exhaustion of the supply of labels during the month, labels which become unstuck during the handling of the claim, and the use of labels on Medicare crossover claims. This approach will also be more costly than a simple identification card.

3. Controls and Audit Trails

In order to ensure that all information is processed both completely and accurately, the following controls and/or audit trails have been established:

Manual Processing

a. A count of all transactions affecting Medicaid eligibility or buy-in activity is maintained by the control clerk and is balanced daily against computer generated totals for the same transactions.

b. All paper work affecting Medicaid eligibility is maintained by the Single State Agency so

that no loss is possible due to transmitting documents from location to location.

c. Recipient Identification Cards are sent to each recipient telling him of his eligibility. The recipient, therefore, has the final check over changes to his eligibility status.

Computer Processing

a. Transactions against the Medicaid Eligibility Master File are matched based on recipient name and date of birth as well as identification number.

b. All data items are edited for completeness and validity before the Medicaid Eligibility Master File or the Buy-In Master File is updated. Erroneous data is not allowed to change the master file data.

c. An Eligibility Error Suspense File and a Buy-In Error Suspense File contain all error records until they are corrected. This is to ensure that all error records get corrected.

d. A Recipient Change Listing is produced by the computer to provide an audit trail to account for every change made to a recipient's record.

e. A Recipient Control Report and Buy-In Control Report are printed by the computer to ensure that all data which enters the system is processed.

f. The Medicaid Eligibility Master File is periodically compared and balanced against the Social Services and SSI master files to ensure that all common data in the files remains in agreement.

g. All data files will be labeled and checked by the computer so that only the proper file can be used for each processing run.

h. Control totals and processing dates will be maintained in each computer file to make certain that all data processing records are accounted for on each processing run.

C. PROCESSING FLOW

1. Introduction

The Recipient Subsystem contains all activities related to the status of recipients eligible for Medicaid benefits. It also coordinates all activities relating to the State Buy-In Program. This subsystem does not certify recipient eligibility nor provide any other Social Services function such as budget calculation, recertification, or quality control of eligibility. This subsystem must rely on the State Social Services Department and SSI to provide information concerning recipient eligibility. The subsystem does make numerous checks, however, to ensure that all data received from Social Services is complete and accurate.

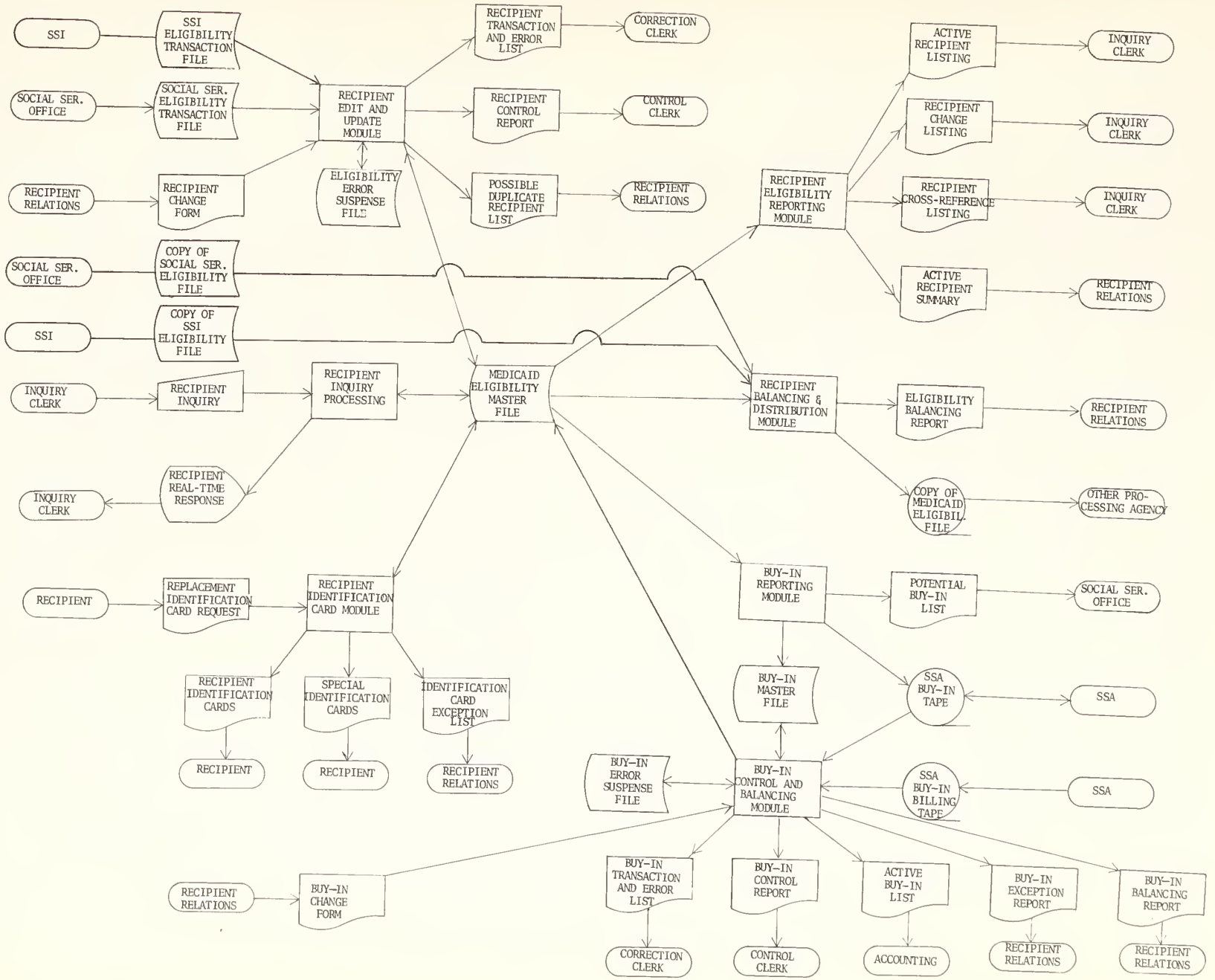
This subsystem handles the maintenance of recipient data on computer files, but does not make payments on behalf of the recipient nor does it print the Explanation of Medical Benefits to be sent to the recipient. Those activities are performed by the Claims Processing Subsystem. Likewise, this subsystem does not build or select recipient profiles. This is a function of the Surveillance and Utilization Review Subsystem. This subsystem prints some reports for operational personnel and low level supervisors in the area of recipient relations. All higher level reports, e.g. trends in recipient enrollments, are contained in the Management and Administrative Reporting Subsystem.

The purpose of this subsystem is to keep track of eligible Medicaid recipients, to keep all recipient information up to date, and to provide this information to the Claims Processing Subsystem, the Surveillance and Utilization Review Subsystem, and the Management and Administrative Reporting Subsystem.

2. Functional Flow Diagram

The Recipient Subsystem Functional Flow Diagram found on the following page graphically depicts the overall processing flow through the Recipient Subsystem.

Recipient Subsystem Functional Flow Diagram



3. Module Descriptions

The Recipient Subsystem is comprised of the modules listed below. The remainder of this section is devoted to descriptions of these modules. Each module is described in turn in the following manner:

a. A brief description of major functions performed and outputs produced.

b. Processing Flowcharts.

c. Process Step Definitions, including special exhibits as required.

The Processing Flowchart provides a schematic of the processing flow within each module indicating each discrete processing step. Individual process steps are identified on the flowchart by a process step number of the form:

RX.YY

where R indicates the Recipient Subsystem

X indicates the module number

YY indicates the number of a process step within that module.

Immediately following the Processing Flowcharts are descriptions of the activities or functions occuring at each process step within the module. These descriptions are presented on the Process Step Definition Sheet. The process step number provides a means of cross reference between the Processing Flowchart and the Process Step Definition Sheets.

Module Number	Module Name	Page Number
R1	Edit and Update	II-23
R2	Real Time Inquiry	II-35
R3	Identification Card	II-39
R4	Eligibility Reporting	II-45
R5	Balancing and Distribution	II-49

Module Number	Module Name	Page Number
R6	Buy-In Reporting	II-53
R7	Buy-In Control and Balancing	II-57

EDIT AND UPDATE MODULE

FUNCTIONS

The Edit and Update Module performs the following major functions:

a. Receives recipient eligibility data from the Social Services Department and SSI.

b. Extracts data pertaining to Medicaid and converts it into the proper format.

c. Processes changes and corrections generated within the Single State Agency.

d. Updates the Medicaid Eligibility Master File with all valid transactions.

e. Identifies incomplete or erroneous data.

f. Corrects incomplete or erroneous data, contacting the Social Services and SSI Offices when necessary.

g. Controls the manual and data processing functions to ensure that all transactions are processed correctly.

h. Prints a list of possible duplicate recipients for verification by recipient relations personnel (in conjunction with the State Social Services or SSI Offices).

OUTPUTS

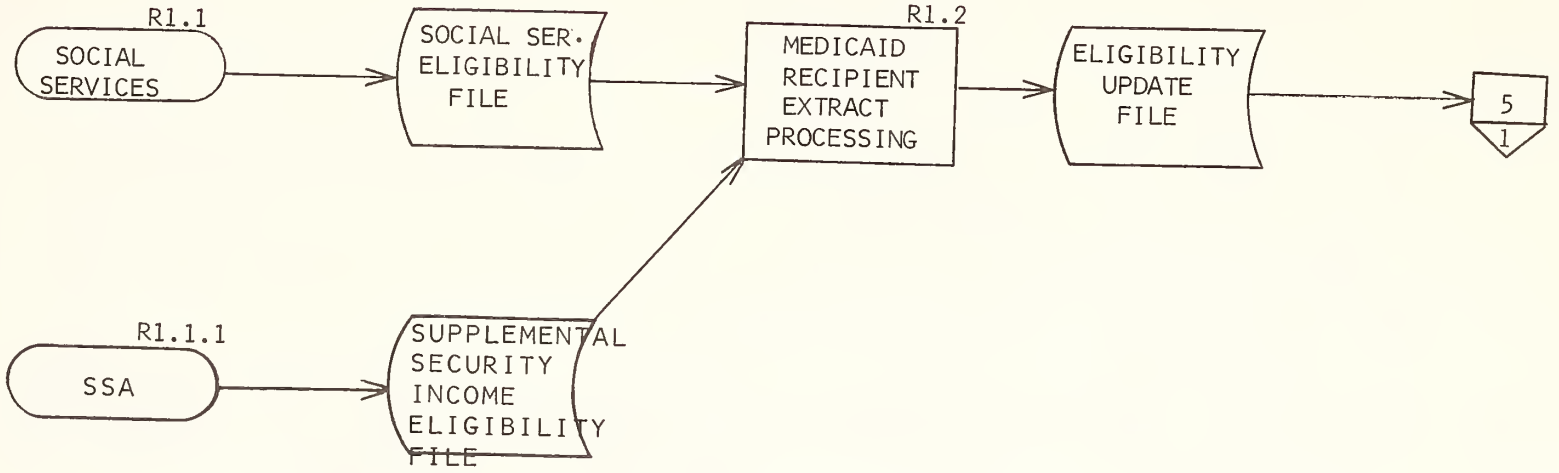
The Edit and Update Module produces the following major outputs:

a. Recipient Error List.

b. Recipient Control Report.

c. Possible Duplicate Recipient List.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - EDIT AND UPDATE MODULE	



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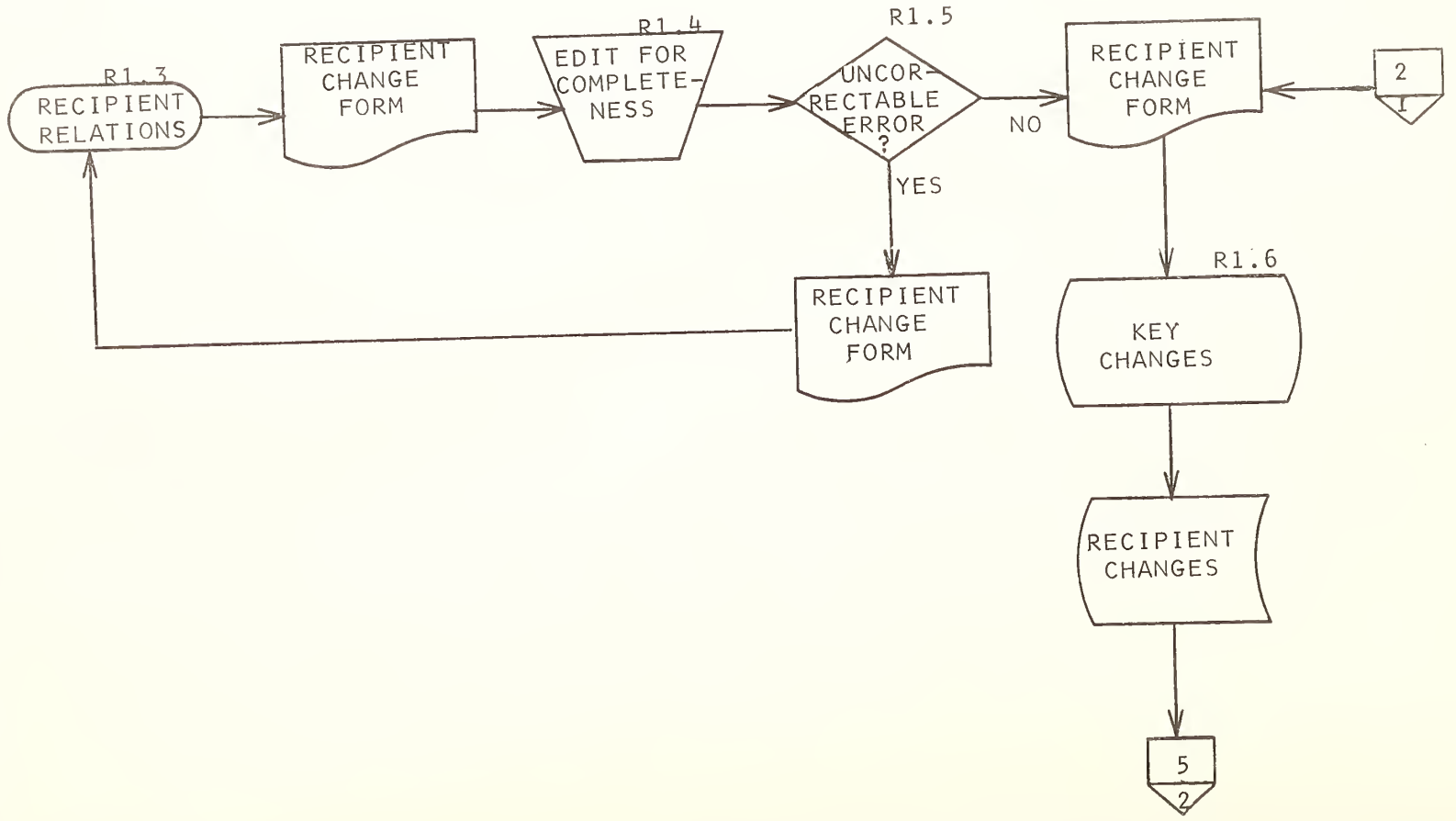
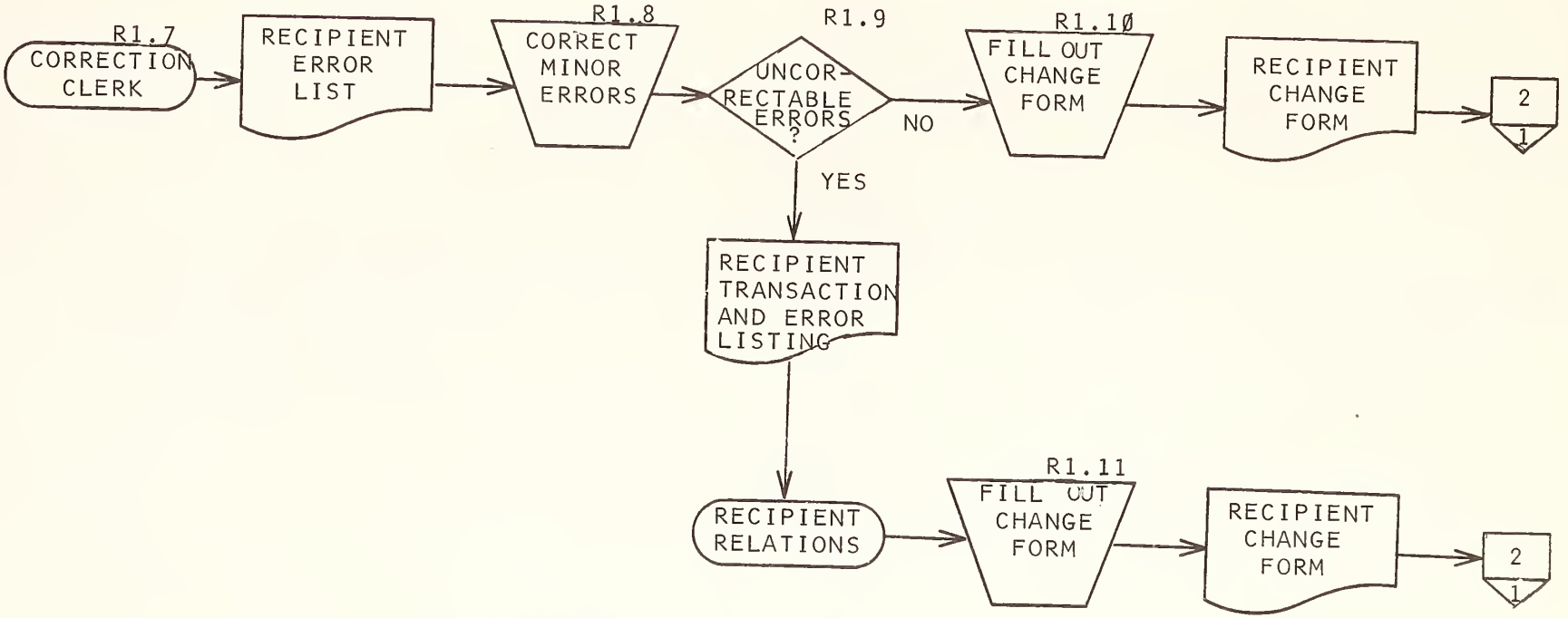
SUBSYSTEM RECIPIENT SUBSYSTEM - EDIT AND UPDATE MODULE	

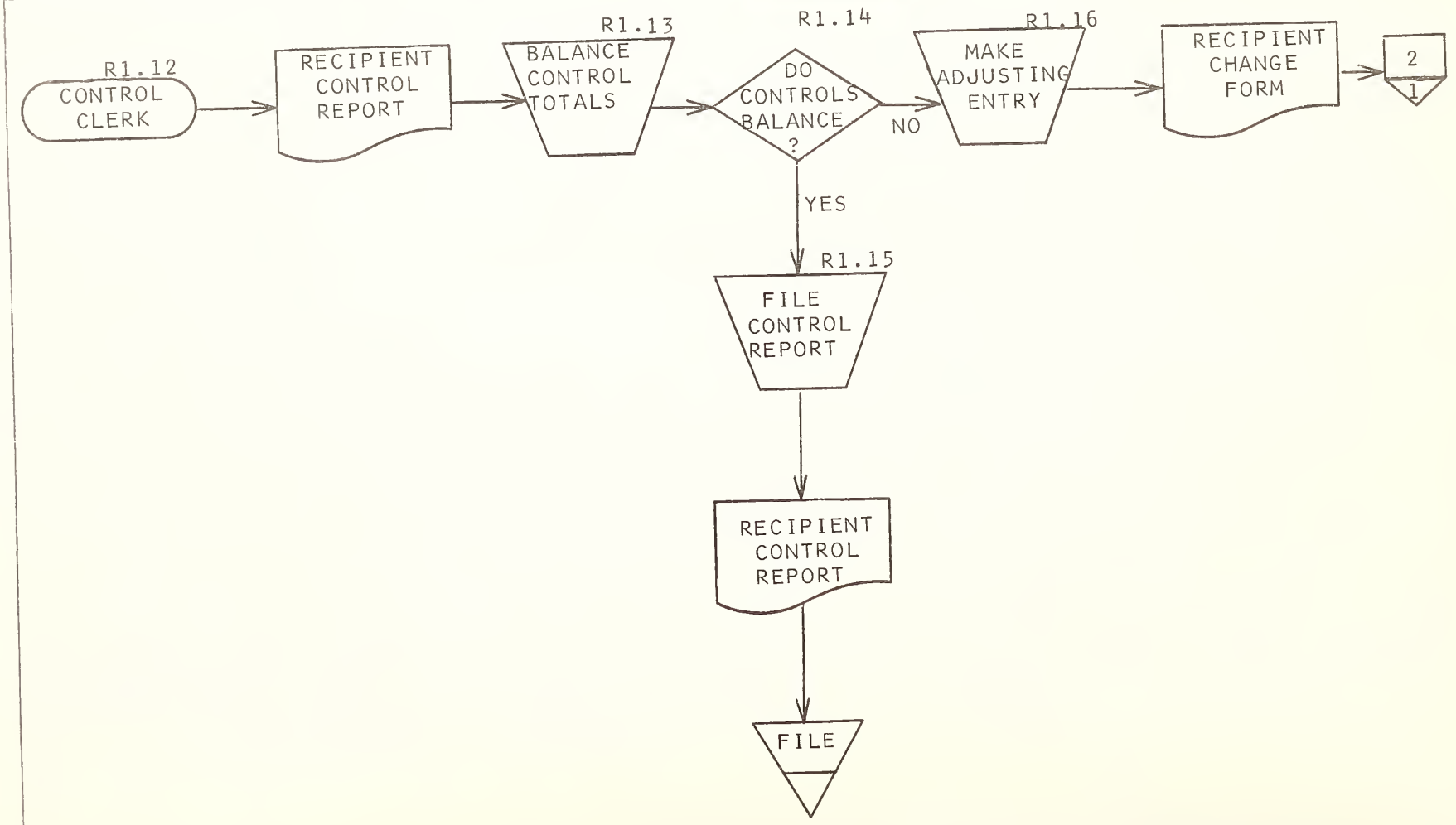


MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - EDIT AND UPDATE MODULE	

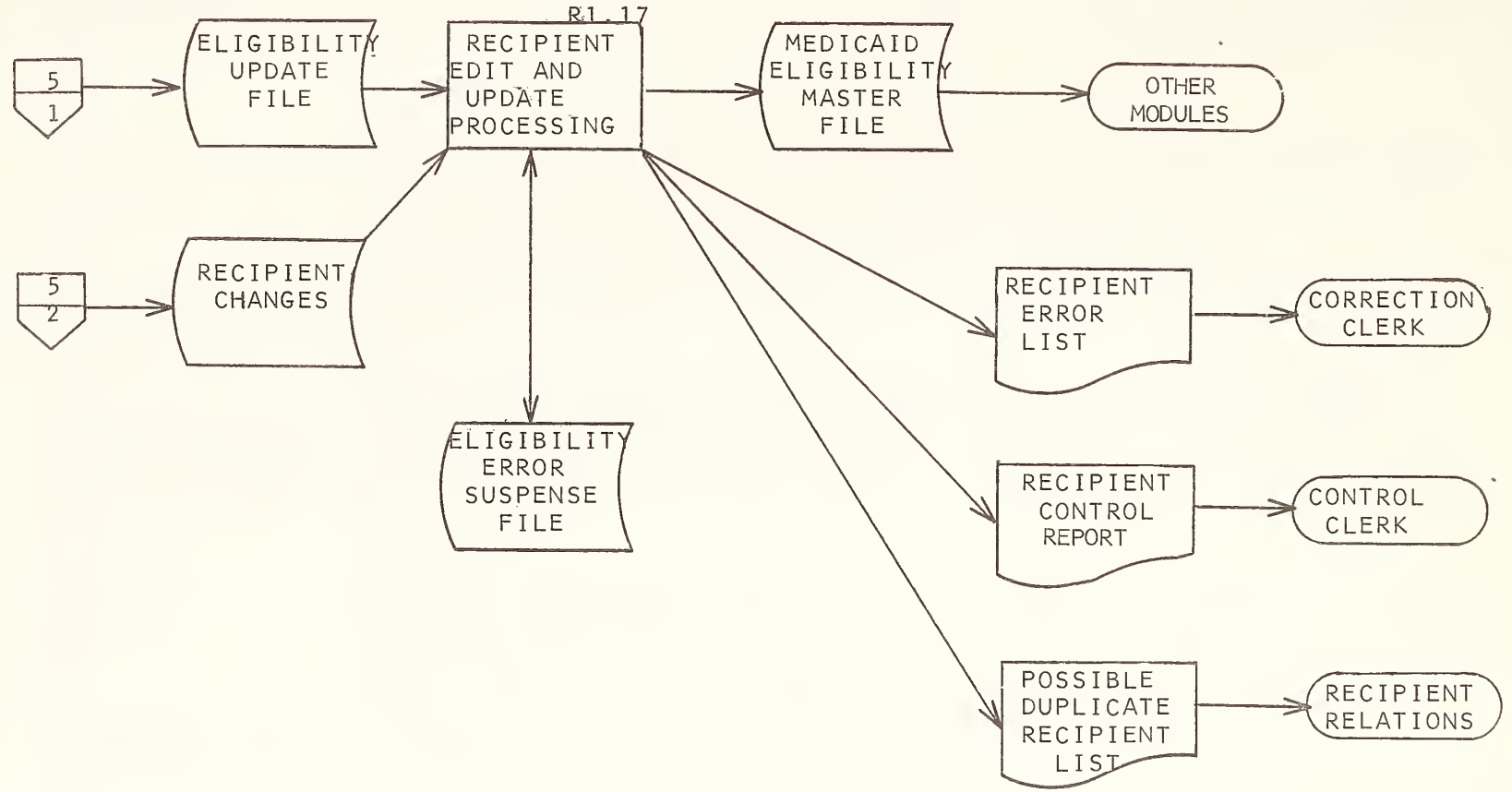


MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART

SUBSYSTEM RECIPIENT SUBYSTEM - EDIT AND UPDATE MODULE



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - EDIT AND UPDATE MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Recipient Subsystem - Edit and Update Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R1.1	Social Services Office	Process all Public Assistance applications, all approvals, all changes and all closures in a timely and efficient manner. Make a copy of each of these Social Services transactions (or generate transaction records from the Social Services update process) and send these transactions to the Single State Agency immediately following each update run.
R1.1.1	Social Security Administration	Process all Supplemental Security Income applications, all changes, and all closures. Determine Medicaid eligibility. Make a copy of all eligibility transactions and send to the Single State Agency.
R1.2	Data Processing	Receive eligibility transactions from the Bureau of Supplemental Security Income of the Social Security Administration and from the State Social Services Department. Extract data related to Medicaid. Reformat data, if necessary, to conform to Medicaid requirements. Retain Medicaid eligibility update transactions for further processing (see Step R1.17 below).
R1.3	Recipient Relations Personnel	Generate transactions, if necessary, to update the Medicaid eligibility file with data unavailable from the Social Services or SSI eligibility files (e.g. the setting of the recipient exception indicator to cause all claims for a given recipient to be manually reviewed prior to payment).

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Recipient Subsystem - Edit and Update Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R1.4	Recipient Edit Clerk	Receive Recipient Change Form from recipient relations section. Screen change form for correctness and completeness, and correct minor errors.
R1.5	Recipient Edit Clerk	Send change forms to data preparation section for keying, for all change forms that are properly completed. Return all incomplete change forms to recipient relations section.
R1.6	Data Preparation Section	Receive Recipient Change Form from recipient edit clerk, error correction clerk or control clerk (see Steps R1.10 and R1.11). Key changes into machine readable form.
R1.7	Error Correction Clerk	Correct the latest error list.
R1.8	Error Correction Clerk	Correct all minor errors such as keying mistakes (by referring to the original change form).
R1.9	Error Correction Clerk	Mark all errors not correctable at this time on the error list and send the error list to the recipient relations section.
R1.10	Error Correction Clerk	Mark out all errors, correctable at this time, on error list, fill out a change form and send it to the data preparation section for keying (see Step R1.6).

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION
SUBSYSTEM Recipient Subsystem - Edit and Update Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R1.11	Recipient Relations Personnel	Contact the Social Services or SSI office if necessary to correct an error. Determine corrections to be made for all errors noted on the error list. Fill out a change form to correct each error and send change forms to data preparation section for keying (see Step R1.6).
R1.12	Control Clerk	Work with Recipient Control Report from previous update processing run (see Step R1.17).
R1.13	Control Clerk	Balance computer generated control totals against manual totals of transactions processed.
R1.14	Control Clerk	Determine if control totals are in balance.
R1.15	Control Clerk	File the in-balance Recipient Control Report in chronological sequence to verify control of all processing on a day by day basis.
R1.16	Control Clerk	Make an adjusting entry, if control totals are not in balance, by filling out a Recipient Change Form to reflect the adjustment. Send Recipient Change Form to data preparation section for keying (see Step R1.6).
R1.17	Data Processing	Process eligibility update transactions from Social Services and SSI.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION
SUBSYSTEM Recipient Subsystem - Edit and Update Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R1.17 (Cont)	Data Processing	Process recipient change transactions generated by the recipient relations section within the Single State Agency. Edit all data for completeness and consistency. Update the Medicaid Eligibility Master File with all valid transactions. Retain all transactions in error on the Eligibility Error Suspense File. Release records from the Eligibility Error Suspense File as the errors from previous runs are corrected. Print a Recipient Error List (with all error transactions flagged) and send the list to the error correction clerk for error correction (see Step R1.7). Print a Recipient Control Report which is sent to the control clerk to balance against manual control totals of transactions processed (see Step R1.12). Check all transactions which add new recipients to the file for possible duplicates with existing records based on name, sex, and age. Print a list of possible duplicate recipients to be used by recipient relations personnel (in conjunction with Social Services personnel) to check for possible duplication of records by Social Services and/or Medicaid.

REAL TIME INQUIRY MODULE
(Optional)

FUNCTIONS

The Real Time Inquiry Module performs the following major functions:

a. Receives an inquiry message from the recipient inquiry clerk.

b. Edits the message for validity.

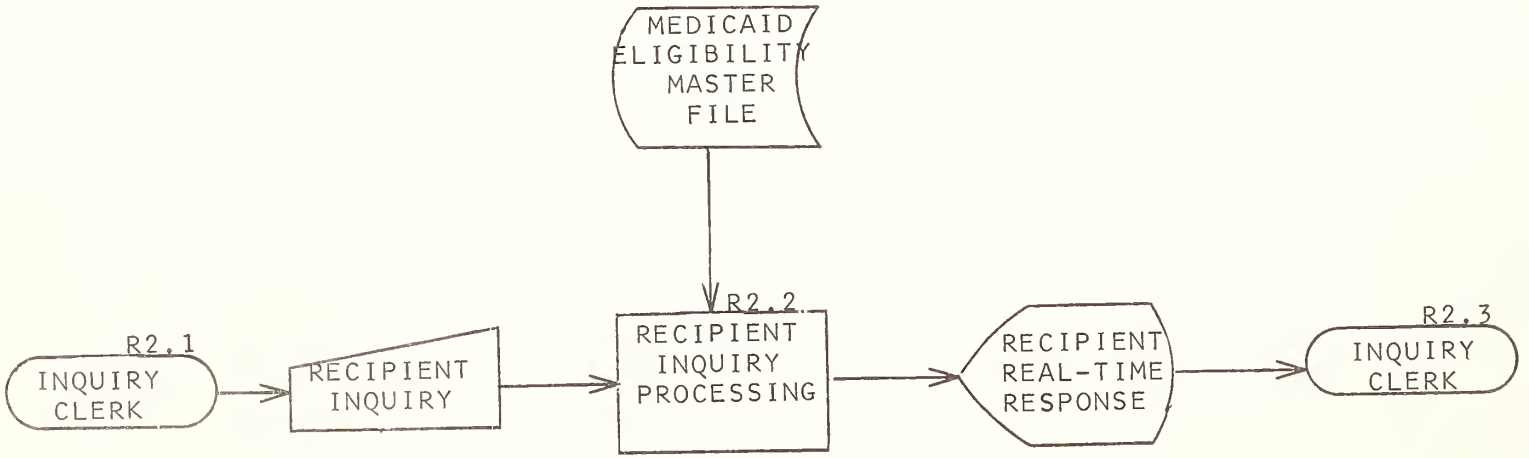
c. Responds with an error message if the inquiry is incorrect.

d. Displays the recipient information requested back to the recipient inquiry clerk.

OUTPUTS

The Real Time Inquiry Module produces no outputs except for a terminal display or terminal printout.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - REAL-TIME INQUIRY MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION
SUBSYSTEM Recipient Subsystem - Real Time Inquiry Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R2.1	Recipient Inquiry Clerk	Key the recipient identification number and inquiry type into a video display console, or typewriter terminal based on a request for information on a specific recipient.
R2.2	Data Processing	Receive the inquiry message. Edit the inquiry message for validity. Respond with an error message if inquiry is incorrect. Retrieve recipient data, for valid inquiries, from the Medicaid Eligibility Master File. Display the requested recipient data back to the recipient inquiry clerk.
R2.3	Recipient Inquiry Clerk	Receive recipient data in the form of a video display or typewriter printout. Answer request for information from the interested party.

IDENTIFICATION CARD MODULE
(Optional)

FUNCTIONS

The Identification Card Module performs the following major functions:

a. Prints Recipient Identification Cards on a monthly basis.

b. Processes requests for replacement identification cards.

c. Prints Special Identification Cards on request.

d. Controls the usage of replacement identification cards by means of an Identification Card Exception List.

OUTPUTS

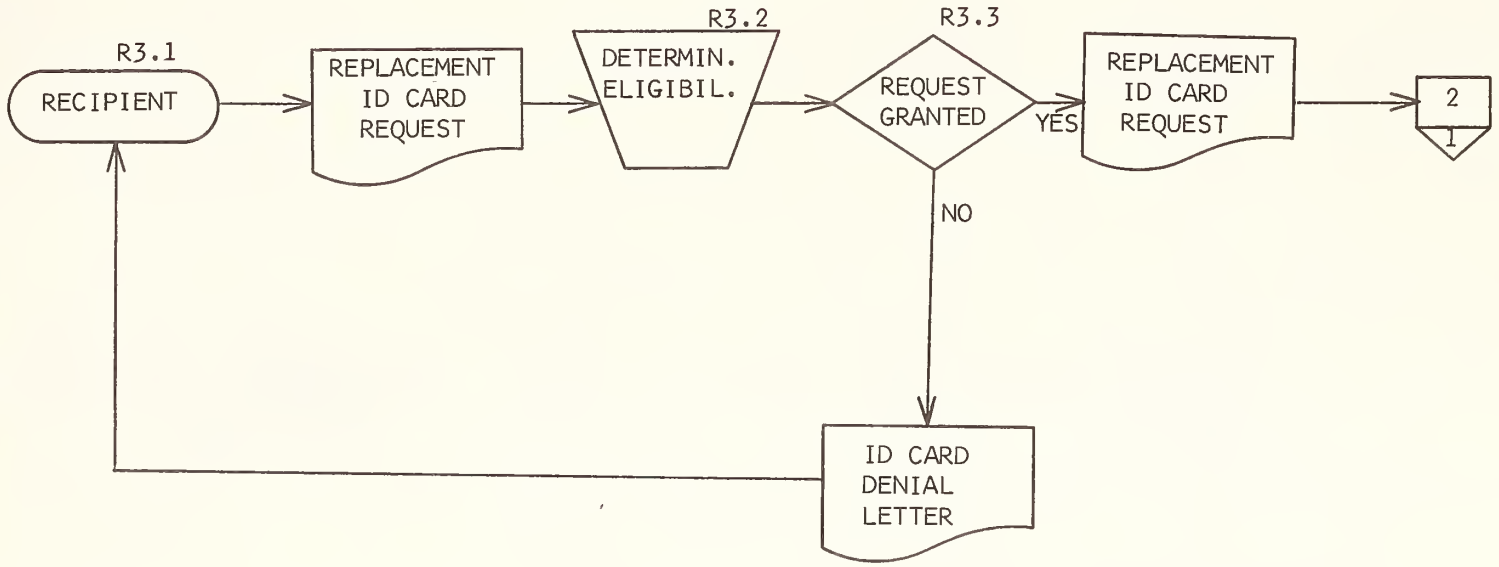
The Identification Card Module produces the following major outputs:

a. Recipient Identification Cards.

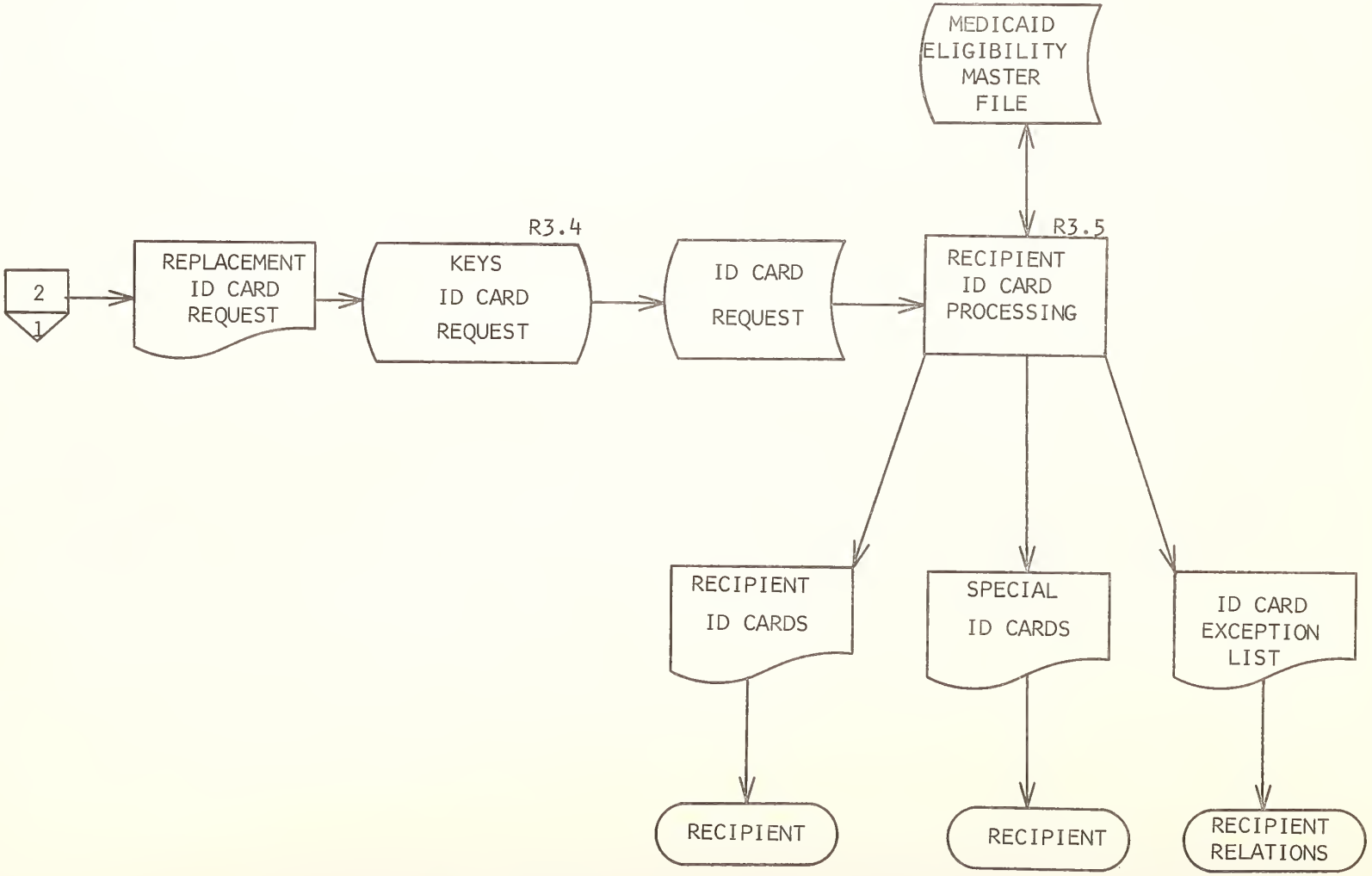
b. Special Identification Cards.

c. Identification Card Exception List.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - IDENTIFICATION CARD MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - IDENTIFICATION CARD MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM Recipient Subsystem - Identification Card Module		
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R3.1	Recipient	Telephone or send in request for a replacement identification card because the original card was not received in the mail or was lost or for some other reason is missing.
R3.2	Recipient Edit Clerk	Receive request for replacement identification card. Verify that the requester is an eligible recipient.
R3.3	Recipient Edit Clerk	Mark the reason, if the request is invalid, on an identification card denial letter and send it to the recipient. Forward, for a valid request, the form requesting a replacement identification card to the data preparation section for keying.
R3.4	Data Preparation Section	Key identification card request into machine readable form.
R3.5	Data Processing	Print regular Recipient Identification Cards for all recipients on a regular (monthly) basis. Based on replacement identification card requests during the month, print Special Identification Cards on request. Print an Identification Card Exception List on a regular basis to provide recipient relations personnel with information on which recipients are getting replacement identification cards, to control possible abuse of the system.

ELIGIBILITY REPORTING MODULE

FUNCTIONS

The Eligibility Reporting Module performs the following major functions:

a. Consolidates information into a meaningful form.

b. Prints reports for use by the recipient inquiry clerk to answer inquiries pertaining to recipient eligibility.

c. Prints an Active Recipient Summary monthly to provide counts of Medicaid recipients by aid category.

OUTPUTS

The Eligibility Reporting Module produces the following major outputs:

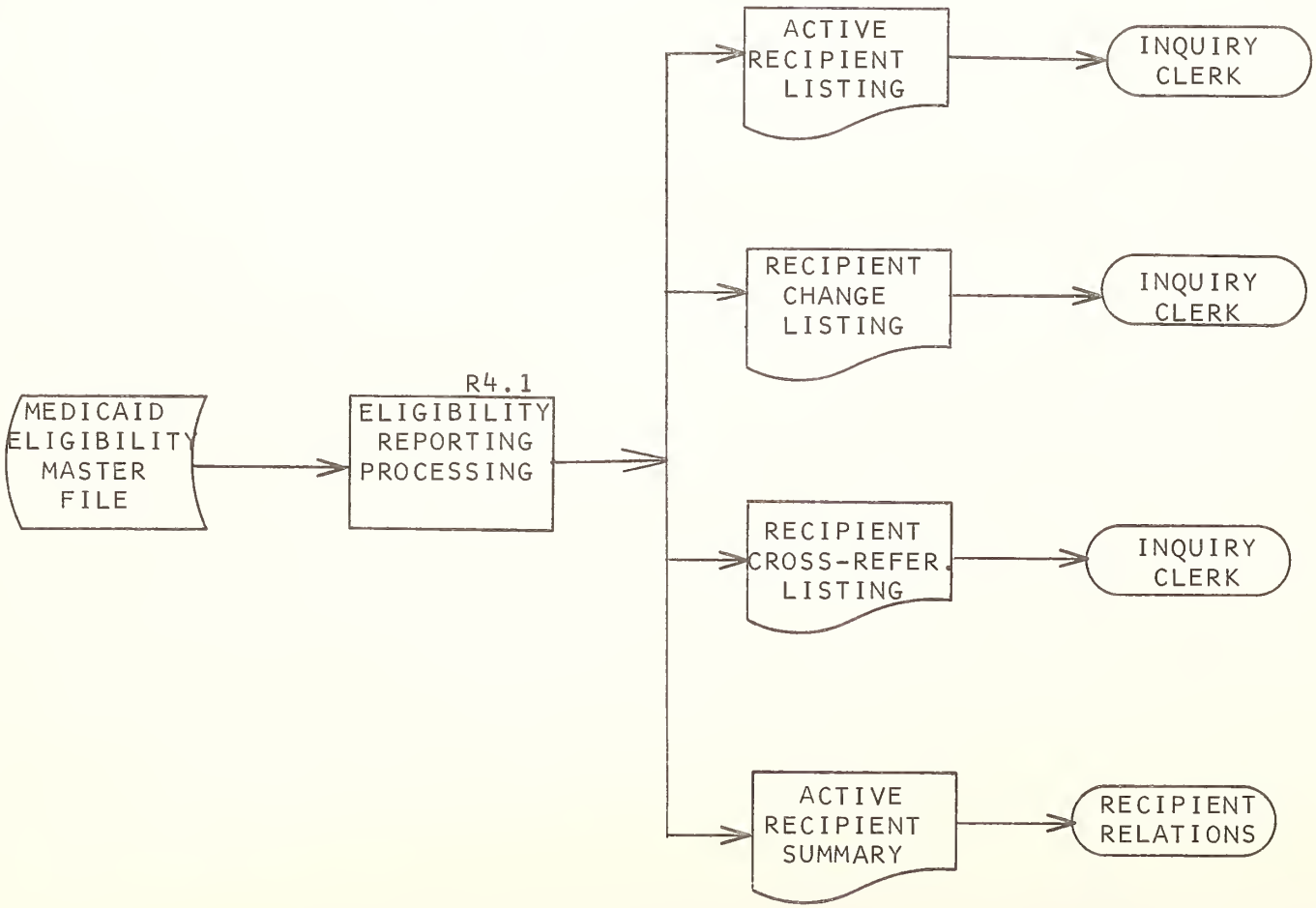
a. Active Recipient Listing.

b. Recipient Change Listing.

c. Recipient Cross Reference Listing.

d. Active Recipient Summary.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - ELIGIBILITY REPORTING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Recipient Subsystem - Eligibility Reporting Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R4.1	Data Processing	Print an Active Recipient Listing, in identification number sequence, every month to answer inquiries, if the real time inquiry module is not used and to serve as a back-up to the real time inquiry process, if that option is elected. Print a Recipient Change Listing daily in identification number sequence, to be used in conjunction with the Active Recipient Listing to show new recipients, changes and closures since the monthly recipient listing was printed. Print a Recipient Cross Reference Listing by recipient, in alphabetical sequence, so that recipient numbers can be obtained from recipient names for inquiry purposes. Print an Active Recipient Summary to provide recipient relations personnel with summary information concerning counts of eligible recipients by assistance category.

BALANCING AND DISTRIBUTION MODULE

FUNCTIONS

The Balancing and Distribution Module performs the following major functions:

a. Periodically compares the Medicaid file with the Social Services and SSI eligibility files in order to identify and correct any discrepancies.

b. Produces a copy of the Medicaid Eligibility Master File to send to other processing agencies.

OUTPUTS

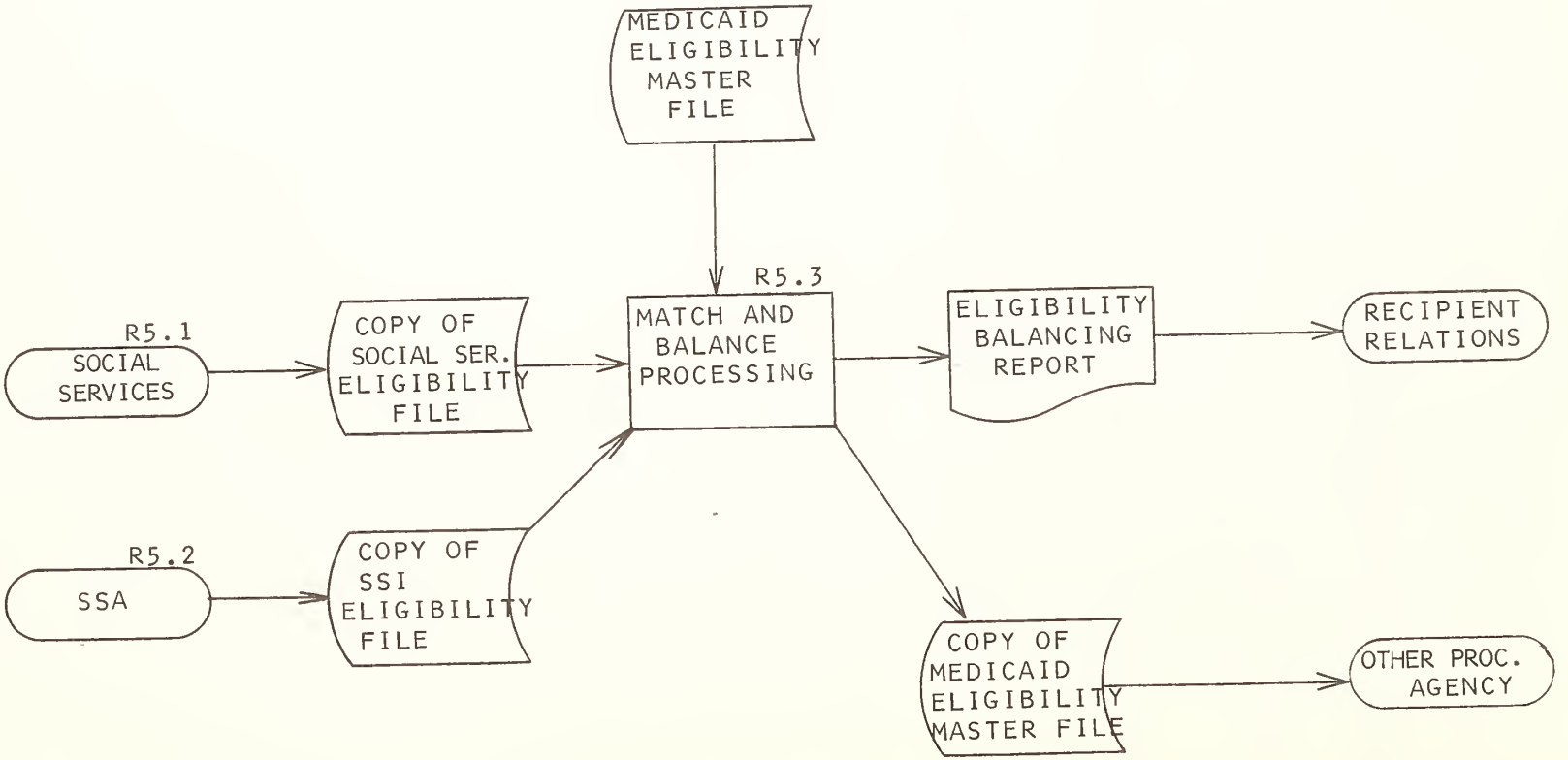
The Balancing and Distribution Module produces the following major outputs:

a. Eligibility Balancing Report.

b. Copy of the Medicaid Eligibility Master File.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART

SUBSYSTEM RECIPIENT SUBSYSTEM - BALANCING AND DISTRIBUTION MODULE



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Recipient Subsystem - Balancing and Distribution Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R5.1	Social Services Office	Periodically send a copy of the Social Services eligibility file to the Single State Agency in order to verify that the same common information is reflected on the Medicaid file and on the Social Services file.
R5.2	Social Security Agency	Periodically send a copy of the State's portion of the Supplemental Security Income eligibility file to the Single State Agency in order to verify that the same common information is reflected on the Medicaid file and on the SSI file.
R5.3	Data Processing	Match the copies of the Social Services and SSI eligibility files against the Medicaid eligibility file. Print out any discrepancies on the Eligibility Balancing Report for action by the recipient relations section (in conjunction with the Social Services Department and SSI). Produce a copy of the Medicaid Eligibility File and send to other processing agencies (as applicable).

BUY-IN REPORTING MODULE

FUNCTIONS

The Buy-In Reporting Module performs the following major functions:

a. Determines all potential buy-in recipients.

b. Prints a listing of all potential buy-in recipients for verification by the Social Services office and to secure any missing data.

c. Generates a transaction tape to send to the Social Security Administration to initiate the buy-in process.

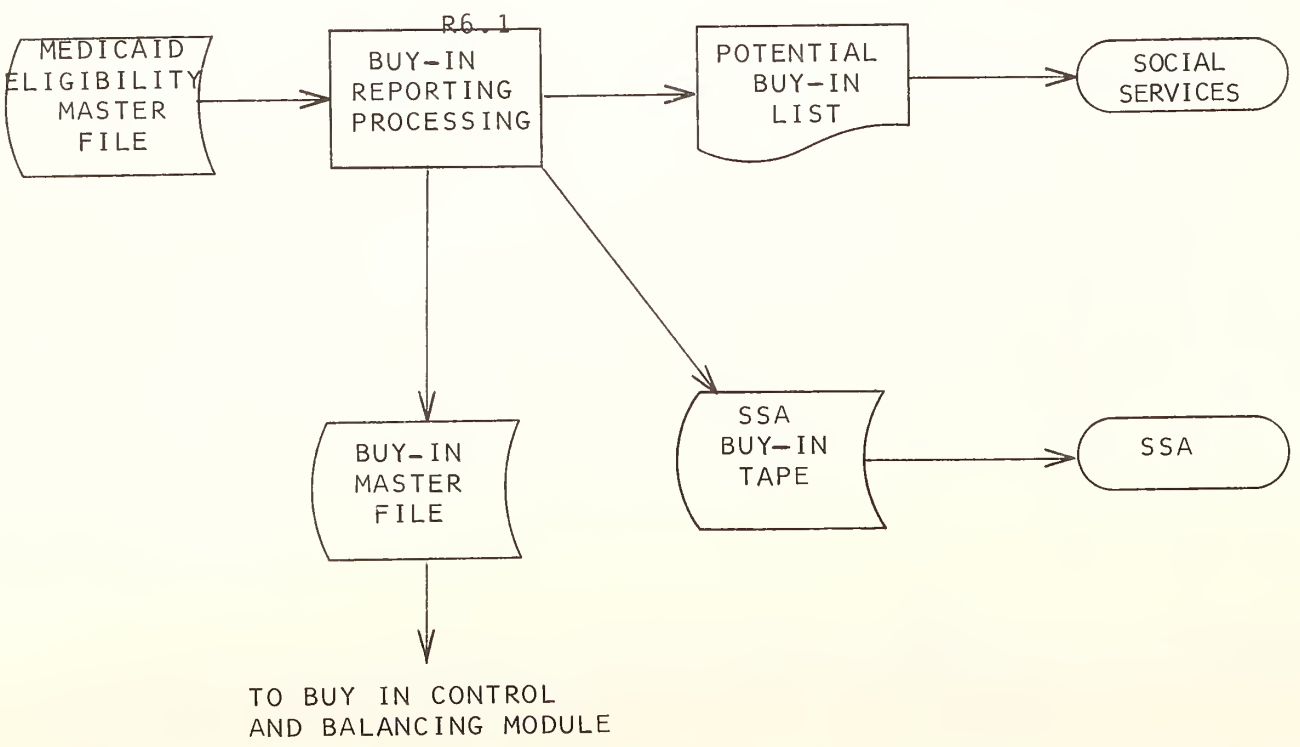
OUTPUTS

The Buy-In Reporting Module produces the following major outputs:

a. Potential Buy-In List.

b. SSA Buy-In Tape.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - BUY-IN REPORTING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Recipient Subsystem - Buy-In Reporting Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R6.1	Data Processing	Select all recipients from the Medicaid Eligibility Master File who have reached the age of 64 years 9 months and up or, not having attained this age, are disabled and are entitled to monthly disability benefits for at least 24 consecutive months and have not yet been bought-in for Part B of Medicare. Add all of the recipients identified for potential buy-in to the Buy-In Master File. Print a listing of all potential buy-in recipients for use by the Social Services office to secure missing Social Security Numbers and other data for those recipients prior to initiation of the buy-in procedure. Generate a tape to be sent to the Social Security Administration containing a record (whose format is specified by SSA) for each recipient to be accreted for the buy-in program.

BUY-IN CONTROL AND BALANCING MODULE

FUNCTIONS

The Buy-In Control and Balancing Module performs the following major functions:

a. Receives buy-in data from the Social Security Administration.

b. Processes buy-in changes and corrections generated within the Single State Agency.

c. Updates the Buy-In Master File with all valid transactions.

d. Identifies incomplete or erroneous data.

e. Corrects incomplete or erroneous data (by contacting SSI and the Social Services office when necessary).

f. Controls the manual and data processing functions to ensure that all transactions are processed correctly.

g. Prints reports to be used by recipient relations personnel to correct any discrepancies between State records and SSA records and to expedite the buy-in process.

OUTPUTS

The Buy-In Control and Balancing Module produces the following major outputs:

a. Buy-In Transaction and Error List.

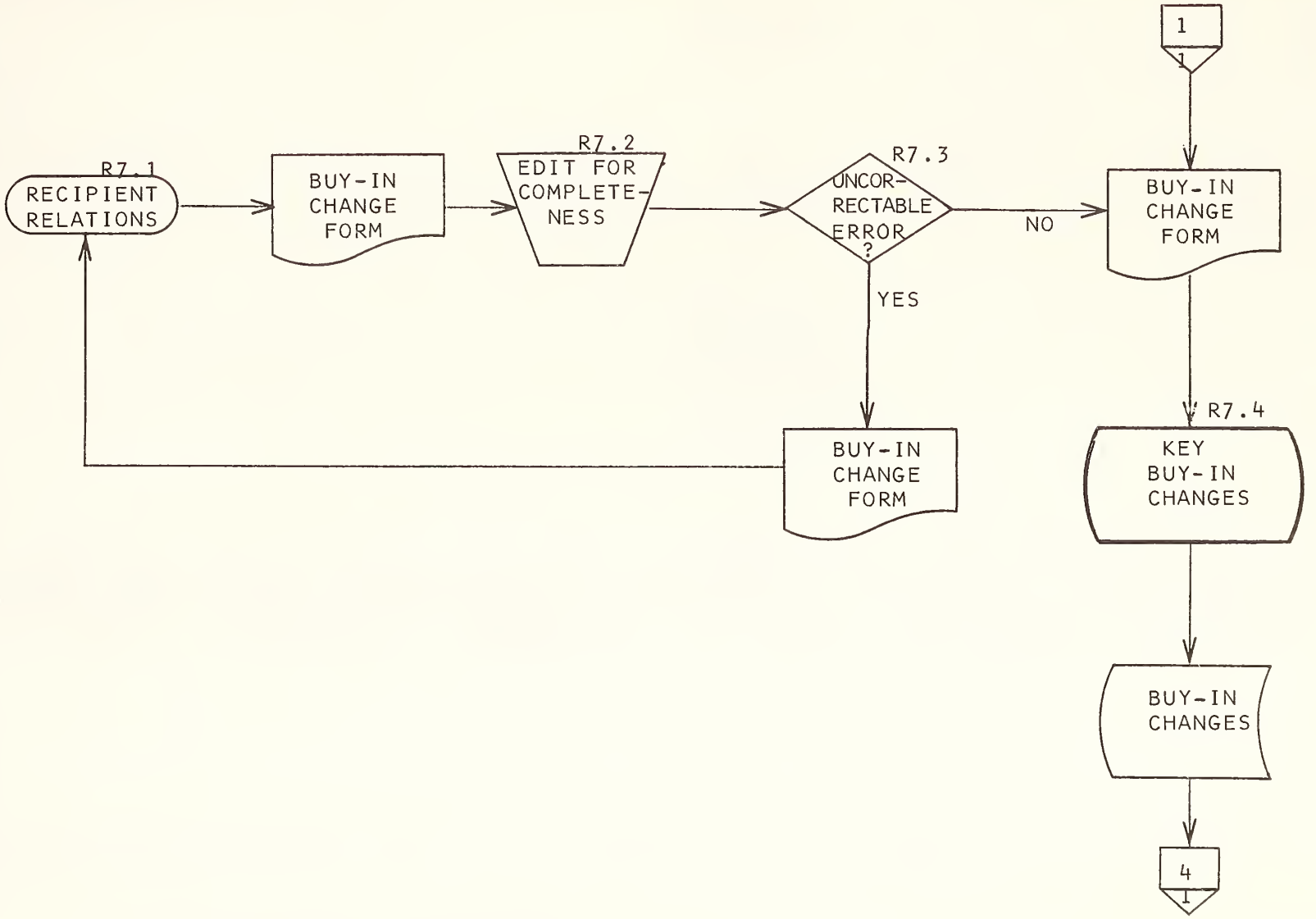
b. Buy-In Control Report.

c. Active Buy-In List.

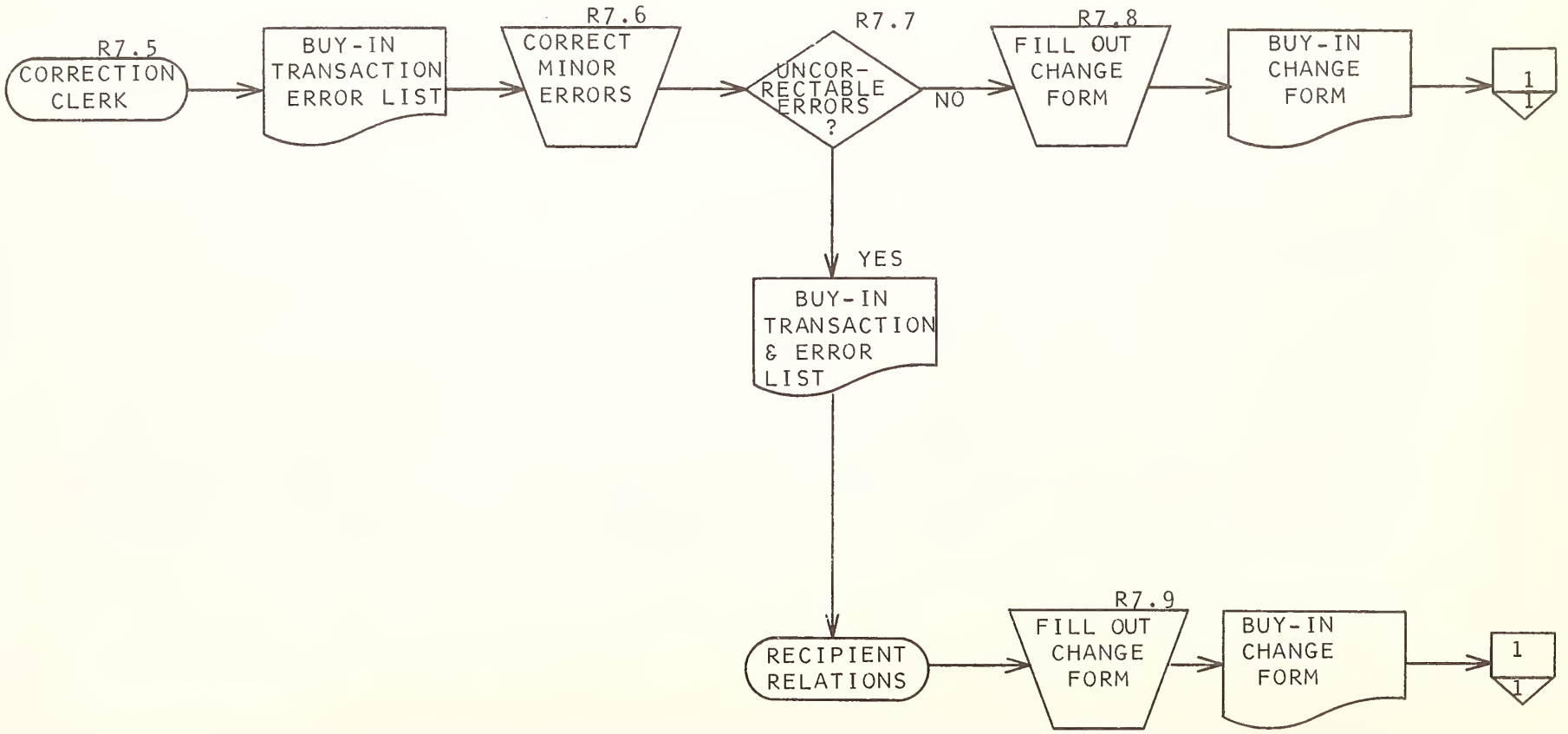
d. Buy-In Exception Report.

e. Buy-In Balancing Report.

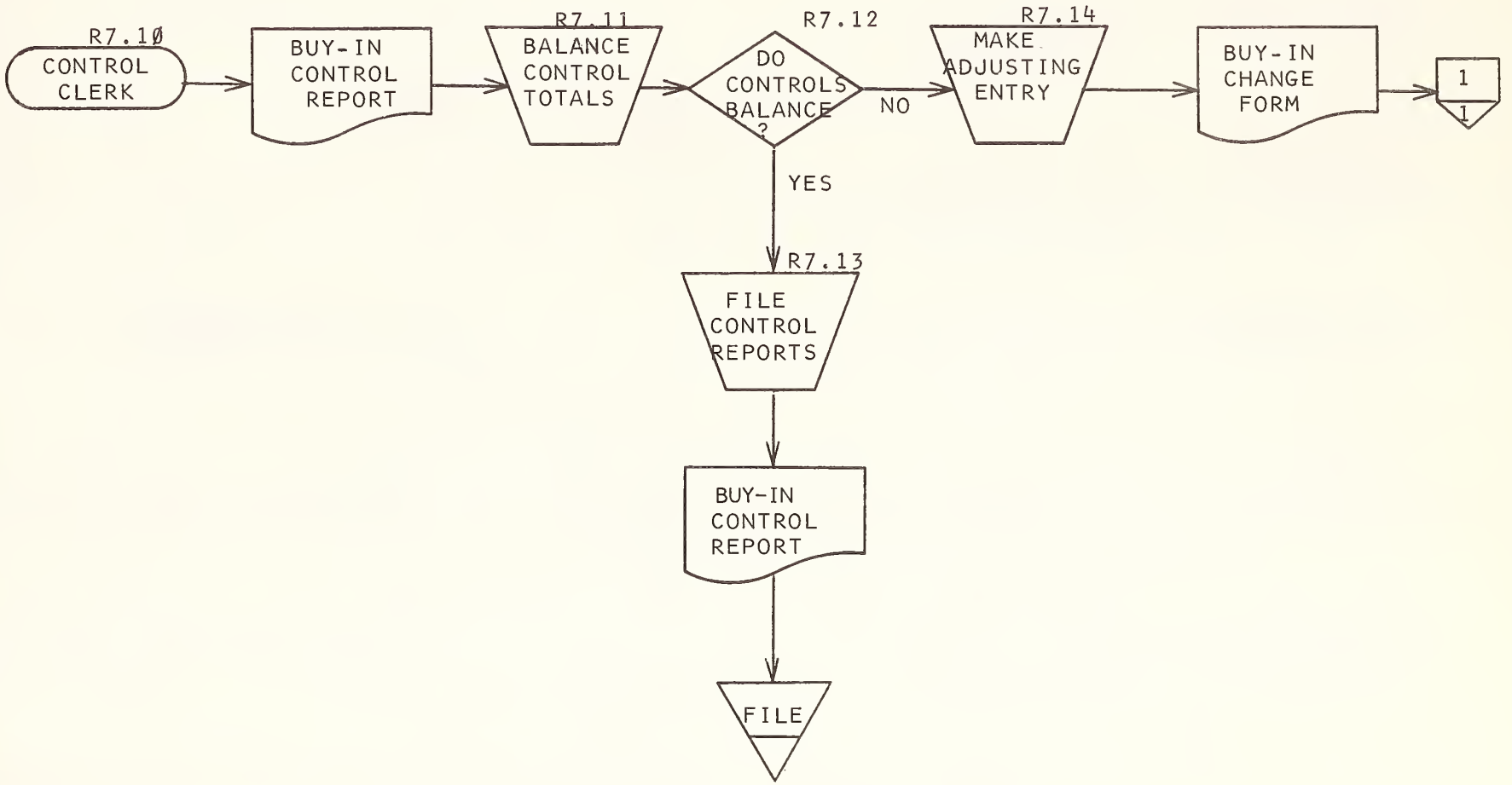
MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - BUY-IN CONTROL AND BALANCING MODULE	



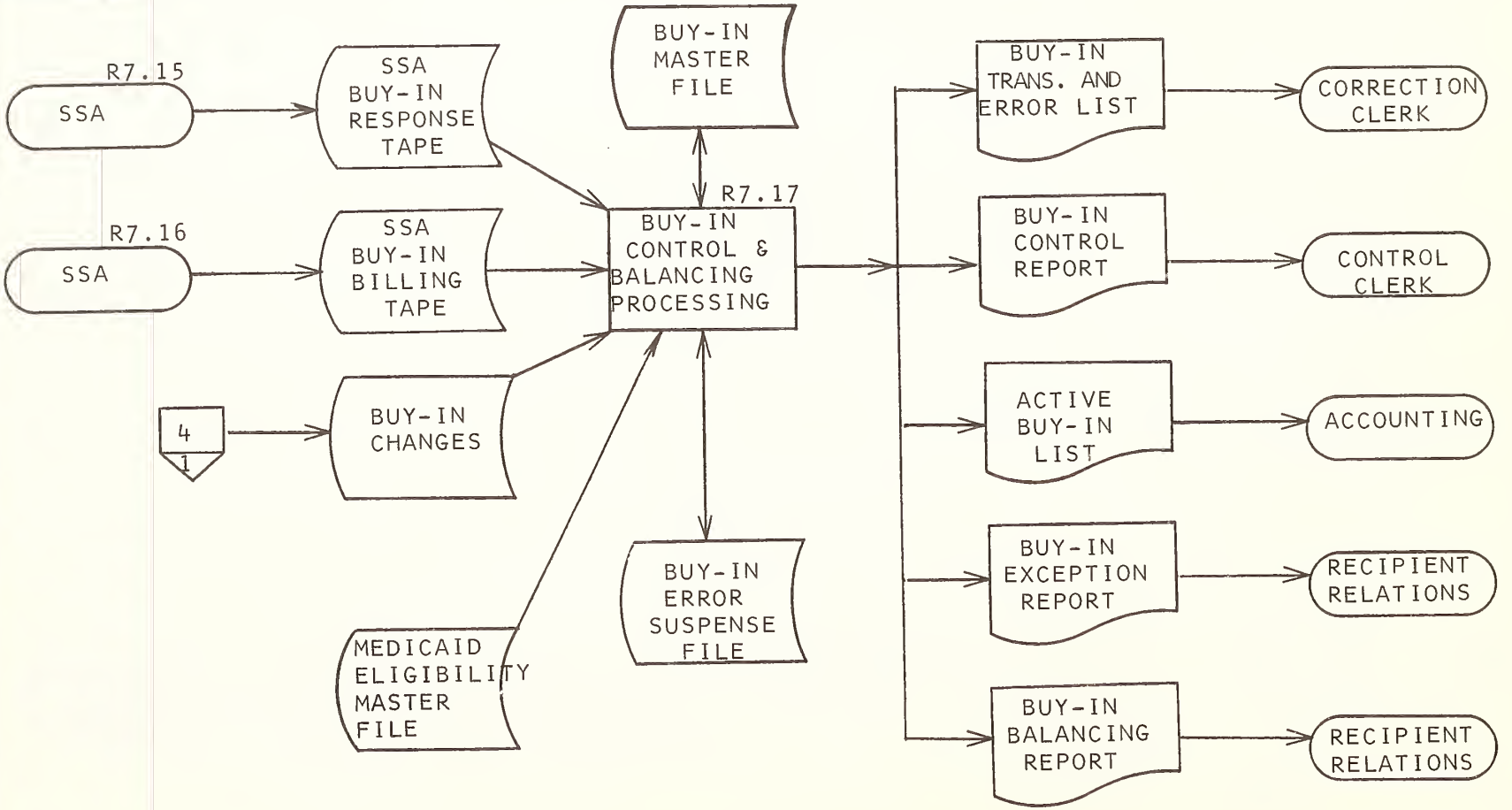
MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - BUY-IN CONTROL AND BALANCING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - BUY-IN CONTROL AND BALANCING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM RECIPIENT SUBSYSTEM - BUY-IN CONTROL AND BALANCING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Recipient Subsystem - Buy-In Control and Balancing Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R7.1	Recipient Relations Personnel	Generate, if necessary, transactions needed to update the Buy-In Master File which cannot be generated from the Medicaid Eligibility Master File or the SSA Buy-In Response Tape. Code transactions on a Buy-In Change Form and send the change form to the recipient edit clerk.
R7.2	Recipient Edit Clerk	Receive Buy-In Change Form from recipient relations section. Screen change form for completeness and correct minor errors.
R7.3	Recipient Edit Clerk	Send all Buy-In Change Forms that are properly completed to data preparation section for keying. Return any incomplete Buy-In Change Forms to recipient relations section.
R7.4	Data Preparation Section	Receive Buy-In Change Forms from recipient edit clerk, error correction clerk, or control clerk (see also Steps R7.8 and R7.9). Key buy-in changes into machine readable form.
R7.5	Correction Clerk	Work from Buy-In Transaction and Error List from previous buy-in control and balancing run (see Step R7.17) to find a means of correcting all errors.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Recipient Subsystem - Buy-In Control and Balancing Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R7.6	Correction Clerk	Correct all minor errors such as keying mistakes (by referring to the original Buy-In Change Form).
R7.7	Correction Clerk	Mark any errors not correctable at this time on the Buy-In Transaction and Error List and send the error list to the recipient relations section.
R7.8	Correction Clerk	Fill out a Buy-In Change Form, for all errors correctable at this time, and send it to the data preparation section for keying (see Step R7.4).
R7.9	Recipient Relations Personnel	Contact SSI and the Social Services office if necessary to correct an error. Determine corrections to be made for all errors on the buy-in error list. Fill out a Buy-In Change Form to correct each error and send change forms to data preparation section for keying (see Step R7.4).
R7.10	Control Clerk	Work with Buy-In Control Report from previous buy-in control and balancing run (see Step R7.17).
R7.11	Control Clerk	Balance computer generated control totals against manual totals of transactions processed.

SUBSYSTEM Recipient Subsystem - Buy-In Control and Balancing Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R7.12	Control Clerk	Determine if control totals are in balance.
R7.13	Control Clerk	File the in-balance Buy-In Control Report in chronological sequence to verify control of all buy-in processing.
R7.14	Control Clerk	Make an adjusting entry, if control totals are not in balance, by filling out a Buy-In Change Form to reflect the adjustment. Send Buy-In Change Form to data preparation section for keying (see Step R7.4).
R7.15	Social Security Administration	Send a Buy-In Response Tape to the Single State Agency containing all recipients submitted to SSA for buy-in or a Buy-In Response Tape of all recipients SSA is attempting to accrete (if automatic accretion process is selected) with each item flagged by SSA to indicate the status of the buy-in activity.
R7.16	Social Security Administration	Send a buy-in billing tape to the state indicating those individuals who have been bought-in and the amount of the buy-in charge (also including retroactive billings for past months).
R7.17	Data Processing	Process Buy-In Response Tape from SSA.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Recipient Subsystem - Buy-In Control and Balancing Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R7.17 (Cont)	Data Processing	Process buy-in billing tape from SSA. Process buy-in change transactions generated at the Single State Agency. Edit all input transactions for validity and completeness. Match all valid input transactions against the Buy-In Master File and update the buy-in file. Transfer the money payment code from the Medicaid Eligibility Master File to the buy-in file so that FFP will not be claimed for premium payments on behalf of non-money payment recipients. Retain all transactions in error on the Buy-In Error Suspense File. Release records from the Buy-In Error Suspense File as the errors from previous runs are corrected. Update the buy-in indicator on the Medicaid Eligibility Master File to reflect the current status of buy-in activities. Print a Buy-In Transaction and Error Listing which serves as an audit trail of all buy-in transactions processed (with all error transactions flagged) and send this list to the error correction clerk for error correction (see Step R7.5). Print a Buy-In Control Report which is sent to the control clerk to balance against manual control totals of transactions processed (see Step R7.10). Print an Active Buy-In List of buy-in premium amounts to be paid by accounting.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Recipient Subsystem - Buy-In Control and Balancing Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
R7.17 (Cont)	Data Processing	Print a Buy-In Exception Report showing those recipients who are eligible for buy-in but have not yet been bought-in, for use by recipient relations personnel to expedite action. Print a Buy-In Balancing Report which shows any discrepancies between SSA records and State or SSI records, for use by recipient relations personnel (in conjunction with Social Services and SSI personnel) to resolve the differences.

D. SUBSYSTEM OUTPUTS

The Recipient Subsystem produces the outputs listed below. The purpose, distribution, and sequence of each output are presented on an Output Definition Sheet. Whenever practical this sheet is followed by a sample report layout that describes the general format and content of the report. The data displayed on the reports is entirely fictitious with little regard given to reasonableness or cross footing of the numbers. The purpose of the sample data is solely one of assistance to the reader in more readily gaining an understanding of the report. The three digit numbers that appear on each report are data element numbers identifying the data elements contained within that report. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

Output Number	Output Name	Page Number
RS-0-Ø1	Recipient Error List	II-72
RS-0-Ø2	Recipient Control Report	II-74
RS-0-Ø3	Possible Duplicate Recipient List	II-76
RS-0-Ø4	Recipient Identification Card	II-78
RS-0-Ø5	Special Identification Card	II-80
RS-0-Ø6	Identification Card Exception List	II-82
RS-0-Ø7	Active Recipient Listing	II-84
RS-0-Ø8	Recipient Change Listing	II-86
RS-0-Ø9	Recipient Cross Reference Listing	II-88
RS-0-1Ø	Active Recipient Summary	II-90
RS-0-11	Eligibility Balancing Report	II-92
RS-0-12	Potential Buy-In List	II-94
RS-0-13	Buy-In Transaction and Error List	II-96
RS-0-14	Buy-In Control Report	II-98
RS-0-15	Active Buy-In List	II-100

Output Number	Output Name	Page Number
RS-0-16	Buy-In Exception Report	II-102
RS-0-17	Buy-In Balancing Report	II-104
RS-0-18	Recipient Real Time Response	II-106
RS-0-19	Copy of Medicaid Eligibility Master File	II-107
RS-0-2Ø	Social Security Administration Buy-In Tape	II-108

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Error List	RS-O-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Edit and Update Module Process Step R1.17	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1. Correction Clerk
2.
3.
4.
5.

SEQUENCE

1.	Recipient Identification Number	4.	
2.	Transaction Date	5.	
3.	Transaction Code	6.	

PURPOSE OF OUTPUT

This report is used as an error listing for correcting recipient errors and for resubmission.

REMARKS

RUN DATE 08/01/71

RECIPIENT ERROR LIST

RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	ERROR FIELD	ERROR FIELD CONTENTS	ERROR REASON
123-456789-01	DOE, JOHN	J	123	OAA	YES	012	123456789HB	INVALID SSA CLAIM NUMBER
						015	01/51/02	INVALID BIRTH DATE
234-567890-10	SMITH, MARY	K	010	APTD	YES	010	08	INVALID SEX CODE
101	**103**		**108**	**109**	**117**	**127**		

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-01

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Control Report	RS-O-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Edit and Update Module Process Step R1.17	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Control Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Aid Category	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report provides control to ensure that all recipient activity is properly entered into the system. It includes a count of recipients by category before and after changes are made and a count of the transactions by type.

REMARKS

RUN DATE 08/01/71

RECIPIENT CONTROL REPORT

AID CATEGORY	MONEY PAYMENT	PREVIOUS TOTAL	RECIPIENTS ADDED	RECIPIENTS DELETED	RECIPIENTS CHANGED	NEW TOTAL	TOTAL TRANSACTIONS
OLD AGE ASSISTANCE	YES	123,456	1,234	789	10,234	124,690	12,257
AID TO THE BLIND	YES	1,234	56	10	123	1,280	189
109	**117**						

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-02

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Possible Duplicate Recipient List	RS-O-Ø3
SUBSYSTEM NAME	DATE
Recipient Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Edit and Update Module Process Step R1.17	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Name	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report lists possible duplicate records as recipients are added to the Medicaid Eligibility Master File. Each new recipient is checked against existing recipients for the same name (with minor variations) and the same birth date. Both records of possible duplicates are printed in this list for follow-up by Social Service or SSI workers.

REMARKS

RUN DATE 08/01/71

POSSIBLE DUPLICATE RECIPIENT LIST

RECIPIENT NAME		BIRTH DATE	RECIPIENT IDENTIFICATION	SOCIAL SECURITY ACCOUNT NUMBER	AID CATEGORY	COUNTY CODE	MONEY PAYMENT	RACE CODE	SEX CODE	ELIGIBILITY BEGIN DATE
DOE, JOHN	J	01/31/02	123-456789-01	123456789	AFDC-C	015	Y	2	M	01/01/69
DOE, JOHN	J	01/31/02	012-345678-09	102030405	AFDC-C	012	Y	2	M	03/08/70
103		105	101	102	109	108	117	106	107	110

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-03

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Identification Card	RS-O-Ø4
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Identification Card Module Process Step R3.5	Monthly
	MEDIA
	Preprinted Form

DISTRIBUTION

1.	Recipients
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

These identification cards are sent to recipients so that they can present them to providers of service to show that they are eligible for Medicaid.

REMARKS

RUN DATE 08/01/71

R E C I P I E N T I D E N T I F I C A T I O N C A R D

RECIPINT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	RACE CODE	SEX CODE	BIRTH DATE	RECIPIENT ADDRESS
123-456789-01	DOE, JOHN	J	012	OAA	YES	1	M	01/31/02	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE, USA 10101
101	103		108	109	117	106	107	105	104

ELIGIBILITY PERIOD	MEDICARE HIB NUMBER	MEDICARE TYPE	THIRD PARTY LIABILITY CD.	BUY IN STATUS	RECIPIENT SCOPE OF COVERAGE CODE
JULY,1971	1234567891	B-ONLY	01	OK	02 (SEE REVERSE SIDE OF CARD FOR EXPLANATION)
110 111		118	113	114	124

II-79

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-04

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Special Identification Card	RS-O-Ø5
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Identification Card Module Process Step R3.5	As requested
	MEDIA
	Preprinted Form

DISTRIBUTION

1. Recipients
2.
3.
4.
5.

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

The special identification cards have the same format as the regular identification cards except that they indicate that they are duplicate cards. They are used to replace identification cards that have been lost or for some reason were not received.

REMARKS

RUN DATE 08/01/71

S P E C I A L I D E N T I F I C A T I O N C A R D

RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	RACE CODE	SEX CODE	BIRTH DATE	RECIPIENT ADDRESS
123-456789-01	DOE, JOHN	J	012	OAA	YES	1	M	01/31/02	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE, USA 10101
101	103		108	109	117	106	107	105	104

ELIGIBILITY PERIOD		MEDICARE HIB NUMBER	MEDICARE TYPE	THIRD PARTY LIABILITY CD.	BUY IN STATUS	RECIPIENT SCOPE OF COVERAGE CODE	
JULY,1971		123456789A	B-ONLY	01	OK		(SEE REVERSE SIDE OF CARD FOR EXPLANATION)
110	111		118	113	114	124	

CARD NUMBER: 2

* * * * * * * * * * * D U P L I C A T E * * * * * * * * * * *

I8-81

REPORT FORMAT SAMPLE

OUTPUT NO. RS-1-05

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Identification Card Exception List	RS-O-Ø6
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Identification Card Module Process Step R3.5	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows which recipients received two (or more) identification cards. It is used to check on the fraudulent use of replacement identification cards.

REMARKS

RUN DATE 08/01/71

I D E N T I F I C A T I O N C A R D E X C E P T I O N L I S T

RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	RACE CODE	SEX CODE	BIRTH DATE	DATES OF CARDS ISSUED	RECIPIENT ADDDRESS
123-456789-01	DOE, JOHN	J	012	OAA	YES	1	M	01/31/02	07/01/71 07/13/71	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE, USA 10101
234-567890-10	SMITH, MARY	K	010	APTD	YES	2	F	08/12/13	07/12/71 07/15/71 07/28/71	ROUTE 2 BOX 353 SMALLTOWN, USA 10101
101	103		108	109	117	106	107	105		104

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-06

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Active Recipient Listing	RS-O-Ø7
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Eligibility Reporting Module Process Step R4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Inquiry Clerk
2.	Single State Agency Central files
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report provides a list of all eligible recipients of Medicaid. It includes all eligible individuals within an AFDC case. It also contains both recipients who receive a money payment and those who do not receive a money payment. (See also the Recipient Change Listing and the Recipient Cross Reference Listing.) This listing is used by the Recipient Inquiry Clerk to answer inquiries pertaining to recipient eligibility. This listing and the Recipient Change Listing also provide an audit trail of all changes made to recipient records.

REMARKS

Optionally, this report may be prepared on microfilm.

RUN DATE 08/01/71

ACTIVE RECIPIENT LISTING

RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	RACE CODE	SEX CODE	BIRTH DATE	MEDICARE HIB NUMBER	RECIPIENT ADDRESS
123-456789-01	DOE, JOHN	J	123	AGED	YES	1	M	01/31/02	123456789A	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE, USA 10101
101	103		108	109	117	106	107	105		

ELIGIBILITY BEGIN - END DATES	DATE OF DEATH	THIRD PARTY	BUY IN	EXCP. IND.	MEDICARE TYPE	I.D. CARD DATE	ASSISTANCE DATE	RECIPIENT LOCATION
07/01/71-08/01/71		01	YES	X	B-ONLY	07/01/71	07/13/71	123
110 111	112	113	114	116	118		132	133

SOCIAL SECURITY NO.	FAMILY INCOME	FAMILY SIZE	PREMIUM AMOUNT	ENROLLMENT FEE	DEDUCTIBLE AMOUNT
898-76-5432	70	1	2.00	3.00	12.00
134	135	136	137	138	392

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-07

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Change Listing	RS-O-Ø8
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Eligibility Reporting Module Process Step R4.1	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Inquiry Clerk
2.	Single State Agency central files
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report is used to supplement the Active Recipient Listing with new recipients who have become eligible since the last Active Recipients Listing was produced and with recipients whose Medicaid status has changed. This listing if used in conjunction with the Active Recipient Listing, will give a complete status of all currently active recipients.

REMARKS

RUN DATE 08/01/71

PAGE 1

RECIPIENT CHANGE LISTING

TRNS TYPE	RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAYMENT	RACE CODE	SEX CODE	BIRTH DATE	MEDICARE HIB NUMBER	RECIPIENT ADDRESS
ADD	123-456789-01	DOE, JOHN	J	123	AGED	YES	1	M	01/31/02	123456749A	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE, USA 10101
	101	103		108	109	117	106	107	105		

ELIGIBILITY BEGIN - END DATES	DATE OF DEATH	THIRD PARTY	BUY IN	EXCP. IND.	MEDICARE TYPE	I.D. CARD DATE	SCOPE OF COVERAGE	ASSISTANCE DATE	RECIPIENT LOCATION
07/01/71-08/01/71		01	YES	X	B-ONLY	07/01/71	03	07/13/71	123
110 111	112	113	114	116	118				

SOCIAL SECURITY NO.	FAMILY INCOME	FAMILY SIZE	PREMIUM AMOUNT	ENROLLMENT FEE	DEDUCTIBLE AMOUNT
898-76-5432	70	1	2.00	3.00	12.00
134	135	136	137	138	392

II-87

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-08

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Cross Reference Listing	RS-0-Ø9
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Eligibility Reporting Module Process Step R4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Inquiry Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Name	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report is used to determine a recipient's identification number when only his name is known. It is then used in conjunction with the Active Recipient Listing to answer inquiries pertaining to recipient eligibility.

REMARKS

RUN DATE 08/01/71

PAGE 1

RECIPIENT CROSS REFERENCE LISTING

RECIPIENT NAME		RECIPIENT IDENTIFICATION	COUNTY CODE	AID CATEGORY	RACE CODE	SEX CODE	BIRTH DATE	SOCIAL SECURITY NO.	RECIPIENT ADDRESS
DOE, JOHN	J	123-456799-01	123	OAA	1	M	01/31/02	123456749	C/O JAMES Q. SMITH 1234 MAIN STREET ANYWHERE USA 10101
SMITH, MARY	K	234-567890-10	010	APTD	2	F	08/12/13	234567890	ROUTE 2 BOX 353 SMALLTOWN, USA 10101
103		101	108	109	106	107	105	134	

II-89

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-09

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Active Recipient Summary	RS-O-1Ø
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Eligibility Reporting Module Process Step R4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Aid Category	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows the total number of recipients and those who were added, deleted, or changed in each aid category. This listing of totals by category is used by research and statistics to determine a count of eligible recipients.

REMARKS

RUN DATE 08/01/71

ACTIVE RECIPIENT SUMMARY

AID CATEGORY	MONEY PAYMENT	PREVIOUS RECIPIENTS	ADDITIONS DURING MONTH	CLOSURES DURING MONTH	CHANGES DURING MONTH	TOTAL RECIPIENTS
OLD AGE ASSISTANCE	YES	123,456	1,234	1,023	10,234	123,667
AID TO THE BLIND	YES	1,234	56	10	123	1,280
109	117					
TOTAL		1,234,567	12,345	10,234	102,345	124,947

II-91

REPORT FORMAT SAMPLE

OUTPUT NO. RS-0-10

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Eligibility Balancing Report	RS-O-11
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Balancing and Distribution Module Process Step R5.3	Quarterly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report lists any records on either the Social Services, SSI, or Medicaid File whenever the common information is not identical between the files.

REMARKS

This report can be run as frequently as needed.

RUN DATE 08/01/71

PAGE 1

E L I G I B I L I T Y B A L A N C I N G R E P O R T

RECIPIENT IDENTIFICATION	SOCIAL SECURITY NO.	RECIPIENT NAME	COUNTY CODE	AID CATEGORY	MONEY PAYMENT	ERROR CONDITION
123-456789-01	898-76-5432	DOE, JOHN J	123	OAA	YES	NO MATCHING RECORD ON SOC SERV ELIG FILE
101	134	103	108	109	177	

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-11

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Potential Buy-In List	RS-O-12
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Reporting Module Process Step R6.1	Monthly
	MEDIA
	Preprinted Form

DISTRIBUTION

1. Local Social Services Office
2.
3.
4.
5.

SEQUENCE

1.	Recipient County Code	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT This report is a list of all recipients who are 64 years and 9 months old or, not having attained this age, are disabled and are entitled to monthly disability benefits for at least 24 consecutive months, and eligible for Medicare Buy-In by the State. This report is used by the local Social Services Office to investigate discrepancies between State and local records and to have the county secure a Social Security Claim Number for those which are missing. This report indicates changes to be made to any other items which would affect Medicare eligibility, thus ensuring that these eligibles are bought-in.

REMARKS

RUN DATE 08/01/71

PAGE 1

POTENTIAL BUY-IN LIST

COUNTY CODE	RECIPIENT IDENTIFICATION	RECIPIENT NAME		SOCIAL SECURITY CLAIM NUMBER	SEX CODE	DATE OF BIRTH	AID CATEGORY	RECIPIENT ADDRESS
001	123-456789-01	DOE, JOHN	J	123456789A	M	04/31/06	APTD	1234 MAIN STREET
108	101	103		102	107	105	109	104

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-12

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Buy-In Transaction and Error List	RS-O-13
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Buy-In Control and Balancing Module Process Step R7.17	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Correction Clerk
2.	Single State Agency Central Files
3.	
4.	
5.	

SEQUENCE

1.	Social Security Claim Number	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report is a listing of all transactions affecting the Buy-In Master File. It serves as an audit trail for all actions affecting buy-in. It is also used as an error listing for correcting buy-in errors for resubmission.

REMARKS

RUNDATE 08/01/71

BUY-IN TRANSACTION AND ERROR LIST

SOCIAL SECURITY CLAIM NUMBER	RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	SEX CODE	DATE OF BIRTH	TRANS TYPE	ERROR CODE	ERROR MEANING
123456799A	123-456789-01	DOE, JOHN	J	123	OAA	M	01/31/71	01	11	INVALID CLAIM NUMBER
102	101	103		108	109	107	105			

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-13

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Buy-In Control Report	RS-O-14
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Buy-In Control and Balancing Module Process Step R7.17	Daily
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Control Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Social Security Claim Number	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report provides control to ensure that all activity affecting the buy-in program is properly entered into the system. It includes a count of all buy-in recipients before and after changes are made and a count of all transactions by type and source.

REMARKS

RUN DATE 08/01/71

PAGE 1

BUY-IN CONTROL REPORT

TRANSACTION SOURCE	PREVIOUS TOTAL	RECIPIENTS ADDED	RECIPIENTS DELETED	RECIPIENTS CHANGED	NEW TOTAL	TOTAL BUY-IN PENDING AT SSA	TOTAL BUY-IN PENDING AT STATE
SSA - BUY IN TAPE	123,456	1,234	789	10,234	124,690	456	321
SSA - BILLING TAPE	124,690			1,234	124,690		

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-14

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Active Buy-In List	RS-O-15
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step R7.17	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Accounting Office
2.	
3.	
4.	
5.	

SEQUENCE

1.	Social Security Claim Number	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report is a summary of recipients for which the buy-in premium is to be paid. It shows all recipients for whom payment is made, and the total debits, credits, and payment amount for the month. It also flags any recipient for which the SSA billing and the Buy-In Master File do not agree.

REMARKS

RUN DATE 08/01/71

A C T I V E B U Y - I N L I S T

SOCIAL SECURITY CLAIM NUMBER	RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	MONEY PAY	SEX CODE	DATE OF BIRTH	CURRENT PREMIUM	RETROACTIVE PREMIUM	EFFECTIVE DATE
1234567894	123-456789-01	DOE, JOHN	J	123	AAA	YES	M	01/31/02	$ 5.65	$ 5.65	06/15/71
102	101	103		108	109	116	107	105	130		

II-101

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-15

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Buy-In Exception Report	RS-O-16
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step 7.17	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Date of Birth	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows all recipients over 64 years old or who have not attained this age but are disabled and are entitled to monthly disability benefits for at least 24 consecutive months and who are eligible for Medicare Buy-In but have still not been accreted by SSA. This is an aged report showing in descending order the recipients who have been pending by length of time.

REMARKS

RUN DATE 08/01/71

PAGE 1

BUY-IN EXCEPTION REPORT

TRANS. DATE	SOCIAL SECURITY CLAIM NUMBER	RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	SEX CODE	ACCRETION CODE	REASON FOR ACTION
01-31-71	123456789A	123-456789-01	DOE, JOHN	J	123	AAA	M	25	DUPLICATE TRANSACTION AT SSA
126	102	101	103		108	109	107	131	

II-103

REPORT FORMAT SAMPLE

OUTPUT NO. RS-7-16

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Buy-In Balancing Report	RS-O-17
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step R7.17	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Recipient Relations Personnel
2.	
3.	
4.	
5.	

SEQUENCE

1.	Social Security Claim Number	4.	
2.	Recipient Identification Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows all unmatched items between the Buy-In Master File and the SSA Buy-In Response Tape from SSA. This is an error list which must be resolved by recipient relations personnel (in conjunction with SSI or the State or local Social Services office) and corrected.

REMARKS

RUN DATE 08/01/71

BUY-IN BALANCING REPORT

SOCIAL SECURITY CLAIM NUMBER	RECIPIENT IDENTIFICATION	RECIPIENT NAME		COUNTY CODE	AID CATEGORY	SEX CODE	DATE OF BIRTH	ERROR CODE	ERROR REASON
123456789A	123-456789-01	DOE, JOHN	J	123	OAA	M	01-31-1902	10	NO MATCHING RECORD ON SSA FILE
102	101	103		108	109	107	105		

II-105

REPORT FORMAT SAMPLE

OUTPUT NO. RS-O-17

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Recipient Real Time Response	RS-O-18
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step R2.2	As requested
	MEDIA
	Terminal Display

DISTRIBUTION

1.	Recipient Inquiry Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This display shows basic eligibility information for each recipient requested. This output would be used to answer inquiries and in error correction instead of the Active Recipient Listing and the Recipient Change Listing.

REMARKS

This design shows only one person having access to a single terminal display. If required, any number of additional terminals could be added.

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Copy of Medicaid Eligibility Master File	RS-O-19
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step R5.2	After eligibility file update
	MEDIA
	Tape

DISTRIBUTION

1.	Any Other Processing Agency
2.	
3.	
4.	
5.	

SEQUENCE

1.	Recipient Identification Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This output is only produced for states that have other processing agencies handling a portion of their Medicaid processing. In these cases, this copy of the Medicaid Eligibility Master File is used in place of the original master file by the other processing agency.

REMARKS

This file is an exact replica of the Medicaid Eligibility Master File (RS-F-Ø1).

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Social Security Administration Buy-In Tape	RS-O-2Ø
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Buy-In Control and Balancing Module Process Step R6.1	Monthly
	MEDIA
	Tape (or Stock Paper)

DISTRIBUTION

1.	Social Security Administration (Baltimore, Maryland)
2.	
3.	
4.	
5.	

SEQUENCE

1.	None	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This output is used for the monthly information exchange between the buy-in State and SSA. This file is used to send records to SSA of all potential buy-in recipients and changes for existing recipients. The specifications for this file are determined by SSA and are found in the State Buy-In Handbook. This file has the same format as the Social Security Administration Buy-In Response Tape (RS-I-Ø6).

REMARKS

Although the option exists to use hard-copy or cards rather than tape for this reporting, no user of the Model System would conceivably use this method.

E. SUBSYSTEM INPUTS

The Recipient Subsystem receives the inputs listed below. The purpose and source of each input are presented on an Input Definition Sheet. This sheet is followed by an Input Description Form that indicates the data elements that are introduced into the system by means of this input. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

Input Number	Input Name	Page Number
RS-I-Ø1	Social Services Eligibility Transaction File	II-110
RS-I-Ø2	Recipient Change Form	II-112
RS-I-Ø3	Replacement Identification Card Request	II-114
RS-I-Ø4	Copy of Social Services Eligibility File	II-116
RS-I-Ø5	Buy-In Change Form	II-118
RS-I-Ø6	Social Security Administration Buy-In Response Tape	II-120
RS-I-Ø7	Social Security Administration Billing Tape	II-122
RS-I-Ø8	SSI Eligibility Transaction File	II-123.1
RS-I-Ø9	Copy of SSI Eligibility File	II-123.3

INPUT DEFINITION

INPUT NAME	INPUT NO.
Social Services Eligibility Transaction File	RS-I-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SEQUENCE	FREQUENCY
Any sequence is acceptable	After each update
	MEDIA
	Cards, tape or disk

SOURCE OF INPUT DATA

State Social Services Office
Process Step R1.1

PURPOSE OF INPUT

The Social Services Eligibility Transaction File contains all of the Public Assistance applications, approvals, changes, and closures for all Medicaid recipients. It may contain various other data not needed by Medicaid. This file is the main source of recipient eligibility data for the Model System.

REMARKS

This file may be the transaction file which is used to update the Social Services master file or it may be a special file generated by the Social Services Department solely for the use of Medicaid.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Social Services Eligibility Transaction File	RS-I-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
117	Money Payment Code	X	
118	Medicare Type Code		X
121	Identification Card Indicator		X
122	Date of Identification Card Issue		X
124	Scope of Coverage Code	X	
302	Transaction Code	X	
126	Transaction Date	X	
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Recipient Change Form	RS-I-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
None	Daily (as needed)
	MEDIA
	Preprinted Form

SOURCE OF INPUT DATA

Recipient Relations Personnel (Process Steps R1.3 and R1.11)
Correction Clerk (Process Step R1.10)
Control Clerk (Process Step R1.16)

PURPOSE OF INPUT

The Recipient Change Form is used by the various personnel within the Single State Agency to make changes (and corrections) as required to certain data fields on the Medicaid Eligibility Master File.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Recipient Change Form	RS-I-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED	MINIMAL
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
114	Buy-In Status Code	X	
116	Recipient Exception Indicator		X
117	Money Payment Code	X	
118	Medicare Type Code		X
121	Identification Card Indicator		X
122	Date of Identification Card Issue		X
123	Buy-In Eligibility Date	X	
124	Scope of Coverage Code		X
302	Transaction Code	X	
126	Transaction Date	X	
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X
134	Social Security Account Number	X	
135	Gross Family Income	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Recipient Change Form	RS-I-Ø2
SUBSYSTEM NAME	DATE
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	
392	Medicaid Deductible Amount	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Replacement Identification Card Request	RS-I-Ø3
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

SEQUENCE	FREQUENCY
None	As required
	MEDIA
	Preprinted Form

SOURCE OF INPUT DATA

Recipient Edit Clerk
Process Step R3.3

PURPOSE OF INPUT

The Replacement Identification Card Request is used to request printing of a Special Identification Card for a recipient who is eligible for Medicaid but for some reason does not presently have a card. (e.g. card was lost, stolen, etc.)

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Replacement Identification Card Request	RS-I-Ø3
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
302	Transaction Code	X	
126	Transaction Date	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Copy of Social Services Eligibility File	RS-I-Ø4
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Any sequence is acceptable	Quarterly
	MEDIA
	Tape

SOURCE OF INPUT DATA

State Social Services Office
Process Step R5.1

PURPOSE OF INPUT

The Copy of the Social Services Eligibility File is an exact replica of the Public Assistance eligibility file(s) used by the Social Services Department. It is used to balance against the Medicaid Eligibility Master File periodically to make certain that the two files stay in balance.

REMARKS

This input can be received as frequently as needed.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Copy of Social Services Eligibility File	RS-I-Ø4
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
117	Money Payment Code	X	
118	Medicare Type Code		X
122	Date of Identification Card Issue		X
124	Scope of Coverage Code	X	
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Buy-In Change Form	RS-I-Ø5
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
None	Daily (as needed)
	MEDIA
	Preprinted Form

SOURCE OF INPUT DATA

Recipient Relations Personnel (Process Steps R7.1 and R7.9)
Correction Clerk (Process Step R7.8)
Control Clerk (Process Step R7.10)

PURPOSE OF INPUT

The Buy-In Change Form is used by various personnel within the Single State Agency to make changes (and corrections) as required to the Buy-In Master File.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Buy-In Change Form	RS-I-Ø5
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address		X
105	Recipient Date of Birth	X	
106	Recipient Race Code		X
107	Recipient Sex Code	X	
108	Recipient County Code		X
109	Recipient Aid Category		X
114	Buy-In Status Code	X	
117	Money Payment Code	X	
123	Buy-In Eligibility Date	X	
302	Transaction Code	X	
126	Transaction Date	X	
129	Buy-In Premium Period		X
130	Buy-In Premium Amount		X

INPUT DEFINITION

INPUT NAME	INPUT NO.
SSA Buy-In Response Tape	RS-I-Ø6
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Social Security Claim Number	Monthly
	MEDIA
	Tape (or Stock Paper)

SOURCE OF INPUT DATA

Social Security Administration (Baltimore, Maryland)

PURPOSE OF INPUT

This input is part of the monthly information exchange between the buy-in State and SSA. This file contains records of all potential buy-in recipients and their status (determined by SSA) with regard to the buy-in. The specifications for this are determined by SSA and are found in the State Buy-In Handbook. This file has the same format as the Social Security Administration Buy-In Tape (RS-0-2Ø).

REMARKS

Although the option exists to use hard-copy or cards rather than tape for this information exchange, no user of this Model System would conceivably use this method.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
SSA Buy-In Response Tape	RS-I-Ø6
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number		X
102	Social Security Claim Number	X	
103	Recipient Name	X	
105	Recipient Date of Birth	X	
107	Recipient Sex Code	X	
117	Money Payment Code	X	
131	SSA Information Exchange Code	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
SSA Buy-In Billing Tape	RS-I-Ø7
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Social Security Claim Number	Monthly
	MEDIA
	Tape (or Stock Paper)

SOURCE OF INPUT DATA

Social Security Administration (Baltimore, Maryland)

PURPOSE OF INPUT

This input contains billing information calculated at SSA and sent to the buy-in State. It contains a record for each eligible buy-in recipient and the recipient's buy-in premium amount. The specifications for this tape are determined by SSA and are found in the State Buy-In Handbook.

REMARKS

Although the option exists to receive this input on hard-copy or cards rather than on magnetic tape, no user of the Model System would conceivably use this method.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
SSA Buy-In Billing Tape	RS-I-Ø7
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number		X
102	Social Security Claim Number	X	
103	Recipient Name	X	
105	Recipient Date of Birth	X	
107	Recipient Sex Code	X	
117	Money Payment Code		X
123	Buy-In Eligibility Date	X	
129	Buy-In Premium Period	X	
130	Buy-In Premium Amount	X	
131	SSA Information Exchange Code	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
SSI Eligibility Transaction File	RS-I-Ø8
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/03/73
SEQUENCE	**FREQUENCY**
Any sequence is acceptable	After each update
	MEDIA
	Cards, tape or disk

SOURCE OF INPUT DATA

SSA

Process Step R1.1.1

PURPOSE OF INPUT

The SSI Eligibility Transaction File contains all of the Title XVI applications, approvals, changes, and closures for all Medicaid recipients. It may contain various other data not needed by Medicaid. This file is a main source of recipient eligibility data for the Model System.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
SSI Eligibility Transaction File	RS-I-Ø8
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
117	Money Payment Code	X	
118	Medicare Type Code		X
121	Identification Card Indicator		X
122	Date of Identification Card Issue		X
124	Scope of Coverage Code	X	
302	Transaction Code	X	
126	Transaction Date	X	
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Copy of SSI Eligibility File	RS-I-Ø9
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73
SEQUENCE	**FREQUENCY**
Any sequence is acceptable	Quarterly
	MEDIA
	Tape

SOURCE OF INPUT DATA

SSA
Process Step R5.2

PURPOSE OF INPUT

The Copy of the SSI Eligibility File is the State's portion of the Supplemental Security Income eligibility file(s) used by SSI. It is used to balance against the Medicaid Eligibility Master File periodically to make certain that the two files stay in balance.

REMARKS

This input can be received as frequently as needed.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Copy of SSI Eligibility File	RS-I-Ø9
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED	MINIMAL
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
117	Money Payment Code	X	
118	Medicare Type Code		X
122	Date of Identification Card Issue		X
124	Scope of Coverage Code	X	
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	

F. SUBSYSTEM FILES

The Recipient Subsystem utilizes the major files listed below. The purpose and nature of each file are presented on a File Definition Sheet. This sheet is followed by a File Description Form that indicates the data element that is maintained within the system by this file. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

A Data Element Input/Output Matrix for the Recipient Subsystem can be found on the last page in this section. This chart provides a summary of which data elements are introduced through the Recipient Subsystem and on which subsystem outputs these data elements are displayed.

File Number	File Name	Page Number
RS-F-Ø1	Medicaid Eligibility Master File	II-126
RS-F-Ø2	Eligibility Error Suspense File	II-128
RS-F-Ø3	Buy-In Master File	II-130
RS-F-Ø4	Buy-In Error Suspense File	II-132

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DEFINITION

FILE NAME	FILE NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FILE TYPE** [X] EDP [ ] MANUAL
Recipient Identification Number	

UPDATE PROCEDURE

Updated daily

PURPOSE AND FUNCTION

The Medicaid Eligibility Master File contains one record for each Medicaid recipient who is eligible now or has been eligible during the past five years. This file contains all data items concerning individual recipients needed for claims payments and other related Medicaid activities. This file is updated every day that there are new eligibility transactions to process or eligibility errors to correct.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code	X	
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
	(data elements 108 through 111 are repeated ten times)		
112	Date of Death	X	
113	Third Party Liability Code	X	
114	Buy-In Status Code	X	
224	Date of Last Transaction		X
116	Recipient Exception Indicator		X
117	Money Payment	X	
118	Medicare Type Code		X
122	Date of Identification Card Issue		X
	(data element 122 is repeated five times)		
123	Buy-In Eligibility Date	X	
124	Scope of Coverage Code		X
132	Recipient Eligibility Certification Date	X	
133	Recipient Location Code		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Medicaid Eligibility Master File	RS-F-Ø1
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	
392	Medicaid Deductible Amount	X	

FILE DEFINITION

FILE NAME	FILE NO.
Eligibility Error Suspense File	RS-F-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Recipient Identification Number, Transaction Date, Type Transaction	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

The Eligibility Error Suspense File is updated each time the Medicaid Eligibility Master File is updated.

PURPOSE AND FUNCTION

The Eligibility Error Suspense File contains one record for each eligibility transaction in error. When all errors on a transaction are corrected, the record is deleted from this file and is allowed to update the Medicaid Eligibility Master File. All eligibility transactions which enter the system are reflected on either this file or on the Medicaid Eligibility Master File. This file ensures that all eligibility error records are corrected. As long as an error remains uncorrected, it stays on this file and is periodically printed on the Recipient Error List.

REMARKS

An aged list of transaction errors that have had no activity in a given time period is generated from the file semi-monthly and is printed as part of the daily recipient error list.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Eligibility Error Suspense File	RS-F-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address	X	
105	Recipient Date of Birth	X	
106	Recipient Race Code		X
107	Recipient Sex Code	X	
108	Recipient County Code	X	
109	Recipient Aid Category	X	
110	Eligibility Begin Date	X	
111	Eligibility End Date	X	
112	Date of Death	X	
113	Third Party Liability Code	X	
114	Buy-In Status Code	X	
116	Recipient Exception Indicator		X
117	Money Payment Code	X	
118	Medicare Type Code		X
122	Date of Identification Card Issue		X
123	Buy-In Eligibility Date	X	
124	Scope of Coverage Code		X
302	Transaction Code	X	
126	Transaction Date	X	
127	Error Field Indicator	X	
128	Error Code	X	
	(data elements 127 and 128 are repeated for all data		
	fields.)		

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Eligibility Error Suspense File	RS-F-Ø2
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
134	Social Security Account Number	X	
135	Gross Family Income	X	
136	Family Size	X	
137	Medicaid Premium Amount	X	
138	Medicaid Enrollment Fee Amount	X	
392	Medicaid Deductible Amount	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DEFINITION

FILE NAME	FILE NO.
Buy-In Master File	RS-F-Ø3
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Social Security Claim Number Recipient Identification Number	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Updated daily

PURPOSE AND FUNCTION

The Buy-In Master File contains one record for each Medicaid recipient who is eligible to be bought-in for Medicare Supplemental Medical Insurance (Part B). This file is maintained separate and apart from the Medicaid Eligibility Master File for ease of processing all Social Security Administration buy-in transactions. The Buy-In Indicator on the Medicaid Eligibility Master File is updated from this file whenever a recipient's buy-in status is changed. This file contains active buy-in recipients and potential buy-in recipients.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Buy-In Master File	RS-F-Ø3
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Names	X	
104	Recipient Address		X
105	Recipient Date of Birth	X	
106	Recipient Race Code		X
107	Recipient Sex Code	X	
108	Recipient County Code		X
109	Recipient Aid Category		X
114	Buy-In Status Code	X	
115	Date of Last Transaction	X	
117	Money Payment Code	X	
123	Buy-In Eligibility Date	X	
129	Buy-In Premium Period		X
130	Buy-In Premium Amount		X
	(data elements 129 and 130 are repeated four times)		
134	Social Security Account Number	X	

FILE DEFINITION

FILE NAME	FILE NO.
Buy-In Error Suspense File	RS-F-Ø4
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Social Security Claim Number, Recipient Identification Number, Transaction Date, Type Transaction	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

The Buy-In Error Suspense File is updated each time the Buy-In Master File is updated.

PURPOSE AND FUNCTION

The Buy-In Error Suspense File contains one record for each buy-in transaction in error. When all errors on a transaction are corrected, the record is deleted from this file and allowed to update the Buy-In Master File. All buy-in transactions which enter the system are reflected on either this file or on the Buy-In Master File. This file insures that all buy-in error records are corrected. As long as an error remains uncorrected, it stays on this file and is periodically printed on the Buy-In Transaction and Error List.

REMARKS

An aged list of transaction errors that have had no activity in a given time period is generated from this file semi-monthly and is printed as part of the daily Buy-In Transaction and Error List.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Buy-In Error Suspense File	RS-F-Ø4
SUBSYSTEM NAME	**DATE**
Recipient Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
101	Recipient Identification Number	X	
102	Social Security Claim Number	X	
103	Recipient Name	X	
104	Recipient Address		X
105	Recipient Date of Birth	X	
106	Recipient Race Code		X
107	Recipient Sex Code	X	
108	Recipient County Code		X
109	Recipient Aid Category		X
114	Buy-In Status Code	X	
117	Money Payment Code	X	
123	Buy-In Eligibility Date	X	
125	Transaction Code	X	
126	Transaction Date	X	
129	Buy-In Premium Period		X
130	Buy-In Premium Amount		X
131	SSA-Information Exchange Code	X	
134	Social Security Account Number	X	

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT
INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Recipient

| INPUT | | | | | | | | | | | | OUTPUT | | | | | | | | | | | |

MEDICAID

MANAGEMENT INFORMATION SYSTEM

SECTION III

PROVIDER SUBSYSTEM

SECTION III

PROVIDER SUBSYSTEM

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III. PROVIDER SUBSYSTEM

A. SUBSYSTEM SUMMARY

1. Objectives

The Provider Subsystem has been developed to accomplish the following primary objectives:

a. Encourage the participation of qualified providers in the Medicaid program.

b. Enroll providers in the Medicaid program after they agree to abide by the rules and regulations of the program.

c. Ensure that providers are qualified to render specific services under the Medicaid program, by screening applicants for state license and certification, by specialty board certification if appropriate, and by visits to the provider by a review team if necessary.

d. Process provider applications and changes in a timely manner and maintain control over all data pertaining to provider enrollment.

e. Build and maintain a computerized file of provider data to be used for invoice processing, administrative reporting, and surveillance and utilization review.

e. Build and maintain a computerized file of provider data to be used for invoice processing, administrative reporting, and surveillance and utilization review.

f. Review enrolled providers on a continuing basis to ensure that they continue to meet eligibility requirements.

2. General Description

The Provider Subsystem can logically be divided into four modules as follows:

a. Certification Module.

b. Edit and Update Module.

c. Rate Change Module.

d. Reporting Module.

These four modules represent four important functional areas within the Provider Subsystem. They do not necessarily reflect the most practical grouping of activities from a data processing or a manual processing point of view. They do, however, present a logical processing flow for each of the four functional areas.

The Certification Module receives applications from providers, determines provider eligibility under Medicaid rules, and approves or rejects provider applications. The Edit and Update Module maintains the computerized provider file through computer processing of approvals, rejections and changes. This module also determines incomplete or erroneous data and provides the means for correcting this information. The Rate Change Module is used for institutional providers to enter or change information regarding per diem rates and percentage factors where institutions are paid on a percent of charge basis. Since a single provider type may have multiple categories of service with different rates (for example, inpatient and outpatient for hospitals and skilled and intermediate care for nursing homes) the rates associated with each category of service can be changed independently. The Reporting Module produces reports of interest to those persons who operate and supervise the provider enrollment function.

The four modules in the Provider Subsystem, taken together, perform the following functions:

a. Processing of provider applications.

b. Determination of eligibility of providers according to Medicaid standards.

c. Editing of data submitted by providers.

d. Correction of erroneous data.

e. Control of provider data.

f. Updating of provider files to reflect the most current status.

g. Notification to providers of approval or rejection of application.

h. Periodic review of enrolled providers to ensure continued eligibility.

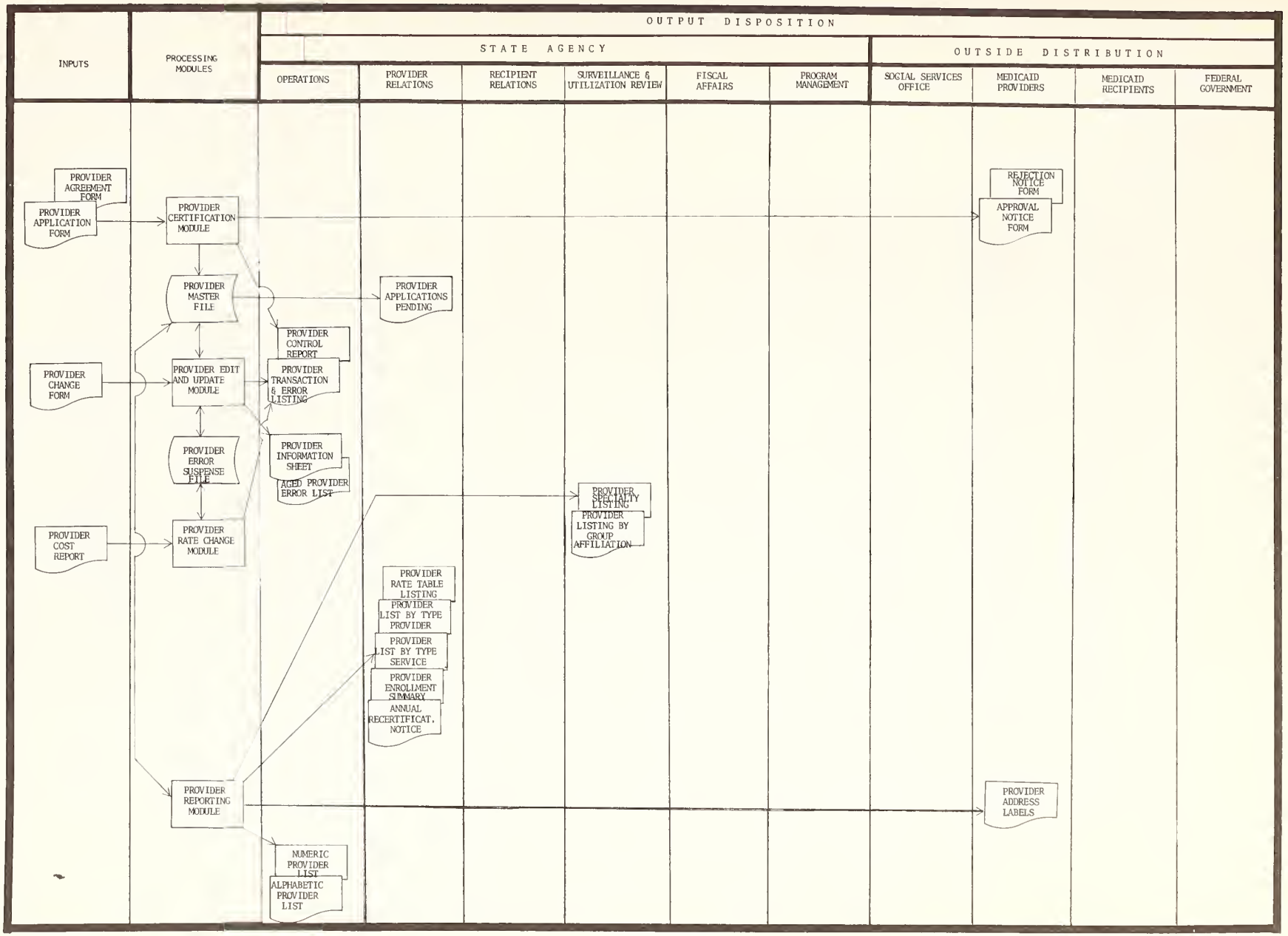
The receipt of applications or changes from providers will be on a daily basis. Applications will be processed as expeditiously as possible and computer updates will be weekly (if update data is present). The

Numeric and Alphabetic Provider Listings are prepared after each weekly update. Special listings are prepared for surveillance and utilization review on an as required basis. Address labels are produced when needed for group mailings to providers. Annual recertification notices and a provider enrollment summary are produced monthly.

3. Information Flow Diagram

The Provider Subsystem Information Flow Diagram found on the following page provides an overview of the Provider Subsystem. The diagram shows the interrelationships of the processing modules and identifies the principal user of each module output. A description of the processing steps and flow of information within the subsystem is presented in detail in Section III-C.

PROVIDER SUBSYSTEM - INFORMATION FLOW DIAGRAM



B. DESIGN ELEMENTS

1. Constraints and Assumptions

The Provider Subsystem was designed based on the following constraints and assumptions:

a. A unique provider number is issued to each provider making application to the Medicaid Program. The number is not subject to reuse by a different provider.

b. Providers will be responsible for initiation of enrollment requests, proper completion of enrollment forms, and notification to the Single State Agency or any change in enrollment data.

c. Provider eligibility will be effective from the date of application.

d. Validation of provider eligibility will be performed annually.

e. All provider enrollment activities will be performed by the Single State Agency.

f. If a State elects to have some part of its Medicaid processing done by another agency, a copy of the Provider Master File will be sent to the other agency after each update.

2. Design Considerations

During the development of the general design of the Provider Subsystem, a number of design decisions were required in areas where more than one approach was feasible. An evaluation was conducted on the advantages and drawbacks connected with each alternative identified, prior to adoption of a particular solution or approach for the Model System. The discussions that follow summarize for each major item of consideration the alternatives explored and the resulting Model System recommendation.

a. Assignment of Provider Numbers

The highly mechanized nature of the Model

System dictates that a provider number be assigned. To ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review, a unique provider number is necessary. The number used by a provider who withdraws from the Medicaid Program must not be used for any other provider.

Any State which has a unique numbering scheme of any kind can continue to use their existing methods of numbering providers under the Model System. For those States which presently do not have a unique number for providers, the following alternatives exist:

(1) Alter the existing number to make it unique.

(2) Use the Medicare provider number.

(3) Use a different numbering scheme for each type provider; for example use the national pharmacy number for drugists.

(4) Use the provider's Social Security Number or the Federal Employer's Tax Identification Number.

(5) Establish a new number which is used only for Medicaid providers.

Since most numbering systems in existence which are not unique cannot easily be converted into unique numbers, item (1) above is difficult to accomplish. The Medicare provider number is already assigned to many Medicaid providers and the use of this number would facilitate the processing of Medicare crossover claims, but many Medicaid providers (for example - druggists) may not be eligible Medicare providers, so some other numbering system will have to be used for providers who do not participate in the Medicare program.

Many Medicaid programs use a different numbering scheme for each type provider. This type of number, however, does not easily accommodate the situation where one provider furnishes several types of service, such as a

physician who also dispenses drugs. Therefore, in order to do a proper job of utilization review, cross-reference tables of numbers are required and the subsequent maintenance of the cross-references can become unwieldy.

The individual provider's Social Security Number and the institutional provider's Federal Employer Identification Number seem to cover the range of all Medicaid providers but could be difficult to administer; for example, in assigning pharmacy numbers to different locations of a large drug store chain.

Primarily because of the reasons listed above, it is recommended, if a unique provider number scheme is not already in use in a State, that a new Medicaid provider number be assigned to each provider participating in the Medicaid program. Furthermore, it is recommended that this new number have a check digit so that the validity of the number can be verified during computer processing, thereby preventing most misdirected payments. The Medicaid number must be unique within all providers and not just unique within one provider type. In conjunction with the provider number, a variable number of codes should be assigned to designate the different types of service a provider can perform. Through this method the utilization review section can analyze all claims from a given provider, or only all claims of a given type.

b. Out-of-State Providers

Since Medicaid payments are based on the residence of the Medicaid recipient and not the location of the provider of service, the State Medicaid system must allow for the enrollment and payment of out-of-state providers. All out-of-state providers fall somewhere in the range beginning with the provider who is located just across the State border and who regularly and routinely provides service to recipients from the adjoining State, and ending with the provider who renders a service to a Medicaid recipient from a distant State and will probably never submit more than one claim to that State for payment.

In the first case, it is obvious that some

out-of-state providers function just like in-state providers and that the enrollment and claims payment processes should be handled in the same way; with the exception that out-of-state providers be so identified. On the other extreme, it is very tempting to establish a mechanism for making one-time payments to providers in distant States without going through all of the normal enrollment processes. However, since it is difficult to project the claim activity of an individual out-of-state provider, and because surveillance and utilization review becomes ineffective without the use of unique provider numbers, it is recommended that all out-of-state providers be enrolled and paid through the same mechanism as in-state providers.

c. Identification of Group Practice Organizations

The Medicaid Program is authorized to make payments to institutions, such as hospitals and nursing homes, and to individual providers, such as doctors and dentists. Somewhere between these two extremes is the area of the group practice. The major question with reference to group practice is whether to identify a provider as being an individual within a group or indistinguishable from the group itself. Since group practice organizations are increasing in numbers every year, this question is becoming increasingly important.

The alternative of identifying and paying the group as an entity seems to be the easiest approach, but problems arise when members of the group also file claims in their own behalf. Therefore, it is recommended that individual persons within a group be assigned unique provider numbers, but that a group number also be assigned to tie individuals of a group together. A separate billing address should also be employed to accommodate providers who use a billing service.

The discussion above does not pertain to prepaid group practices such as Health Maintenance Organizations (HMO's). Since there are relatively few HMO's operating on a prepaid basis at present, the Model System has been

designed as a claims-oriented system and does not address the unique requirements of a pre-payment system.

d. Eligibility Periods

Providers may voluntarily drop out of the Medicaid program at any time and may be enrolled again at a later date. Providers may also be suspended and then reinstated. For these reasons, multiple beginning and ending dates have been allowed for each category of service a provider is eligible to render. Also, rejected providers and suspended providers are assigned numbers and are retained on the Provider Master File for control purposes even though they are not eligible for payment. The only alternative to multiple eligibility periods is to assign a new provider number for a second eligibility period, but this violates an assumption previously stated that a provider is assigned a unique number. The multiple eligibility periods also allow payment of claims on a retroactive basis with the absolute assurance that the provider was eligible at the time of service.

e. Preprinted Invoices

Some states send eligible providers preprinted claim forms to be used for submitting their invoices to Medicaid. The intention of this approach is to reduce the amount of information which has to be written on the claim form and therefore reduce the possibilities for coding errors. A similar approach is to send each provider a rubber stamp or other device to mark each claim before it is submitted. Problems with both of these approaches involve the logistics of keeping the providers supplied with the forms or stamps or other devices, and ensuring that the data remains current when changes are made. The first approach can also cause trouble if one provider runs out of forms and borrows from another provider. The second approach causes problems if the stamp or mark on the form is not legible.

The Model System will accommodate any of these approaches which an individual State may determine is most effective. However, preprinted invoices have not been specified in the

general design of the Model System except in those cases where OCR is used for input. It is desirable that this type of invoice be computer printed to reduce the number of OCR rejects. An individual State desiring to incorporate an approach similar to the ones listed above will have to make appropriate design modifications in the detailed design process.

f. Degree of Automation in the Provider Subsystem

Although the general design of the Provider Subsystem implies that the subsystem is highly automated, no automation is essential. In many smaller States, the volume of data to be processed by the subsystem will be quite small. Such small volumes could be easily processed even when some automatic procedures are replaced by manual steps. Before automating any procedure, the procedure should be carefully studied to determine the cost-justification of the automated process. In some cases, it will be more economical to use manual procedures with no loss of efficiency or accuracy.

3. Controls and Audit Trails

In order to insure that all information is processed both completely and accurately, the following controls and/or audit trails have been established:

Manual Processing Controls:

a. All applications, changes, rejections and other transactions between the provider and the Single State Agency are logged on the applications control log which is balanced daily against computer generated totals of the same transactions.

b. Computer generated approvals and rejections are sent to the provider informing him of his status. The provider thus has the ultimate control over his application being processed correctly.

c. A Provider Correspondence File is maintained for each provider and contains a copy of all transactions against his record so that an audit trail can be established if necessary to verify changes to his record.

d. All provider number assignments are entered on a master provider number list to ensure that provider numbers are not reused.

e. A pending application file is maintained for those applications requiring a visit from the review team to the provider.

f. All paper work is maintained by the Single State Agency so that loss due to transmitting documents is prevented.

Data Processing Controls:

a. Provider transaction records are matched to the provider master record by means of a unique provider number. This number contains a check digit and is edited for validity to ensure that digits of the number have not been written down or keyed incorrectly or transposed during data preparation.

b. All data items are edited for completeness and consistency before the Master Provider File is updated. Erroneous data is not allowed to change the master file.

c. An error suspense file contains all error records until they are corrected to ensure that all errors are eventually corrected.

d. A pending applications file is maintained on the computer to ensure that action is taken on every application.

e. A transaction listing is produced by the computer to provide an audit trail to account for every change made to a provider's record.

f. A control report is printed by the computer to balance against manual totals of data to ensure that all data is processed.

g. All files will be labeled and checked by the computer so that only the proper file can be used for each processing run.

h. Control totals and processing dates will be maintained in each file to make certain that all data processing records are accounted for on each processing run.

C. PROCESSING FLOW

1. Introduction

The Provider Subsystem contains all activities related to enrollment of providers, certification of eligibility, updating the provider's record and keeping rates which are on a provider-by-provider basis. This subsystem does not maintain rates which apply for all providers of a given type nor does it actually make payments to providers. Those functions are performed in the Reference File Subsystem and the Claims Processing Subsystem respectively. Likewise, this subsystem does not build or select provider profiles. That is a function of the Surveillance and Utilization Review Subsystem. This system does produce certain reports for operational personnel and low level supervisors in the provider relations area. All higher level reports, however, are contained in the Management and Administrative Reporting Subsystem.

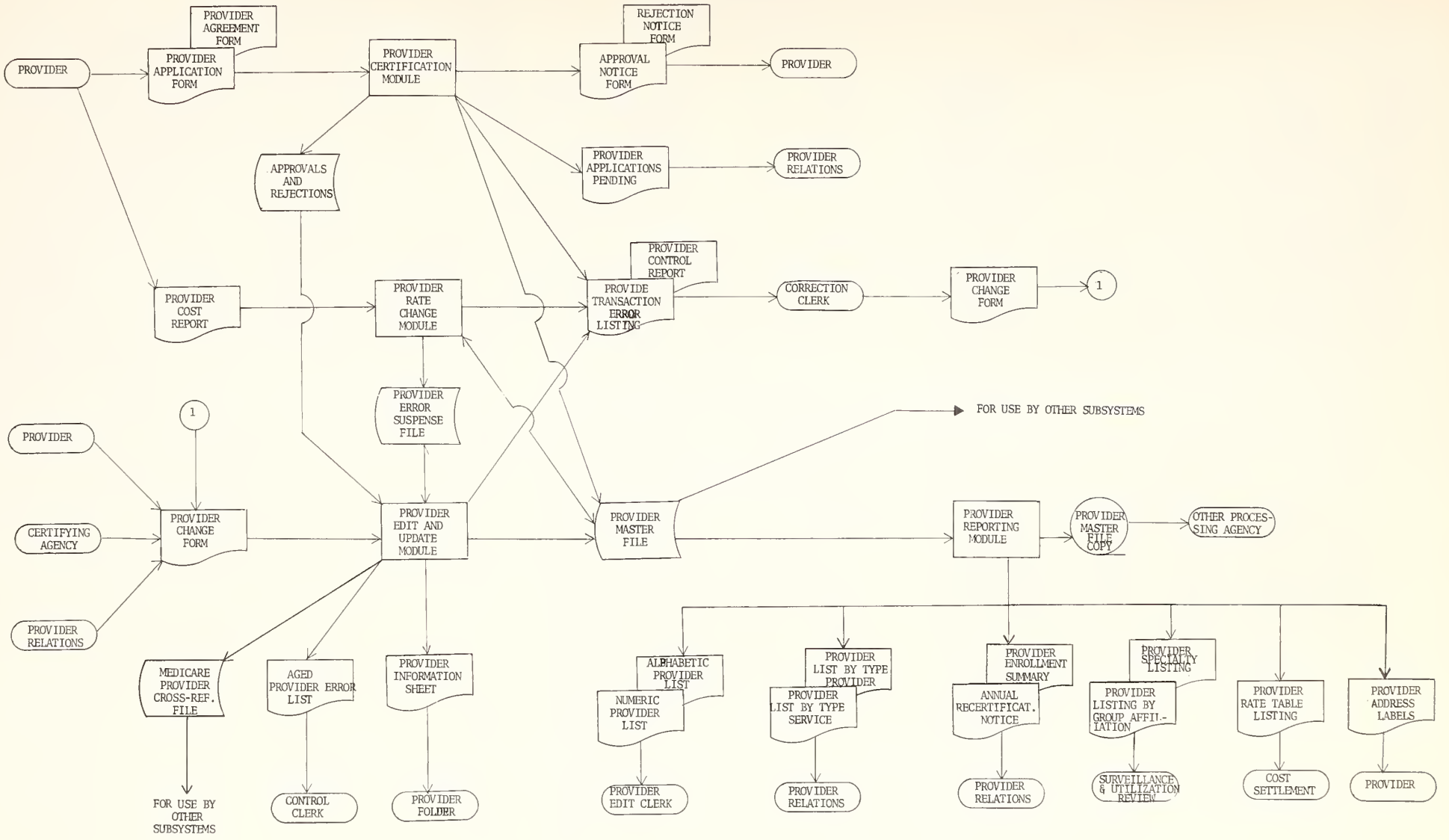
The purpose of this subsystem is to enroll providers, to keep their information current, and to provide this information to the Claims Payment Subsystem, the Surveillance and Utilization Review Subsystem, and the Management and Administrative Reporting Subsystem. In order to perform this job effectively, the following primary functions are necessary:

1. Certification of eligibility.
2. Editing and updating of provider information.
3. Rate change editing and updating.
4. Reporting related to provider enrollment.

2. Functional Flow Diagram

The Provider Subsystem Functional Flow Diagram found on the following page graphically depicts the overall processing flow through the Provider Subsystem.

Provider Subsystem Functional Flow Diagram



3. Module Descriptions

The Provider Subsystem is comprised of the modules listed on this page. The remainder of this section is devoted to descriptions of these modules. Each module is described in turn in the following manner:

a. A brief description of major functions performed and outputs produced.

b. Processing Flowcharts.

c. Process Step Definitions, including special exhibits as required.

The Processing Flowchart provides a schematic of the processing flow within each module indicating each discrete processing step. Individual process steps are identified on the flowchart by a process step number of the form:

PX.YY

where P indicates the Provider Subsystem.

X indicates the module number.

YY indicates the number of a process step within that module.

Immediately following the Processing Flowcharts are descriptions of the activities or functions occurring at each process step within the module. These descriptions are presented on the Process Step Definition Sheet. The process step number provides a means of cross reference between the Processing Flowchart and the Process Step Definition Sheets.

Module Number	Module Name	Page Number
P1	Certification	III-18
P2	Edit and Update	III-33
P3	Rate Change	III-45
P4	Reporting	III-53

CERTIFICATION MODULE

Functions

The Certification Module performs the following functions:

a. Receives applications from providers.

b. Assigns provider numbers.

c. Determines eligibility to participate in the Medicaid program.

d. Updates the Provider Master File with applications, approvals, and rejections.

e. Prints approval and rejection notices.

f. Keeps track of pending applications.

Outputs

The Certification Module produces the following major outputs:

a. Approval Notice Form.

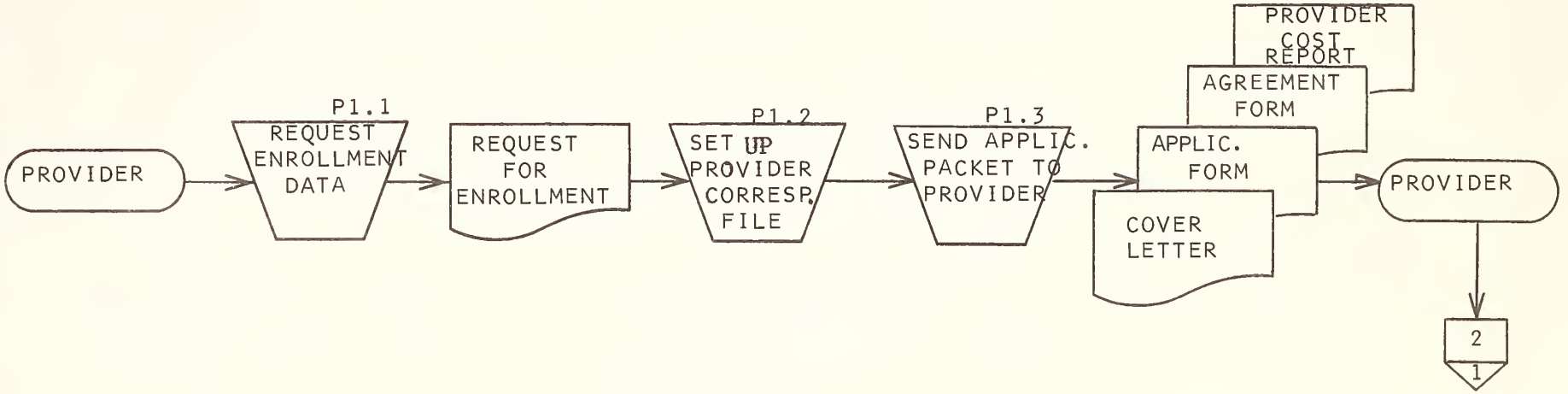
b. Rejection Notice Form.

c. Provider Transaction and Error Listing.

d. Provider Control Report.

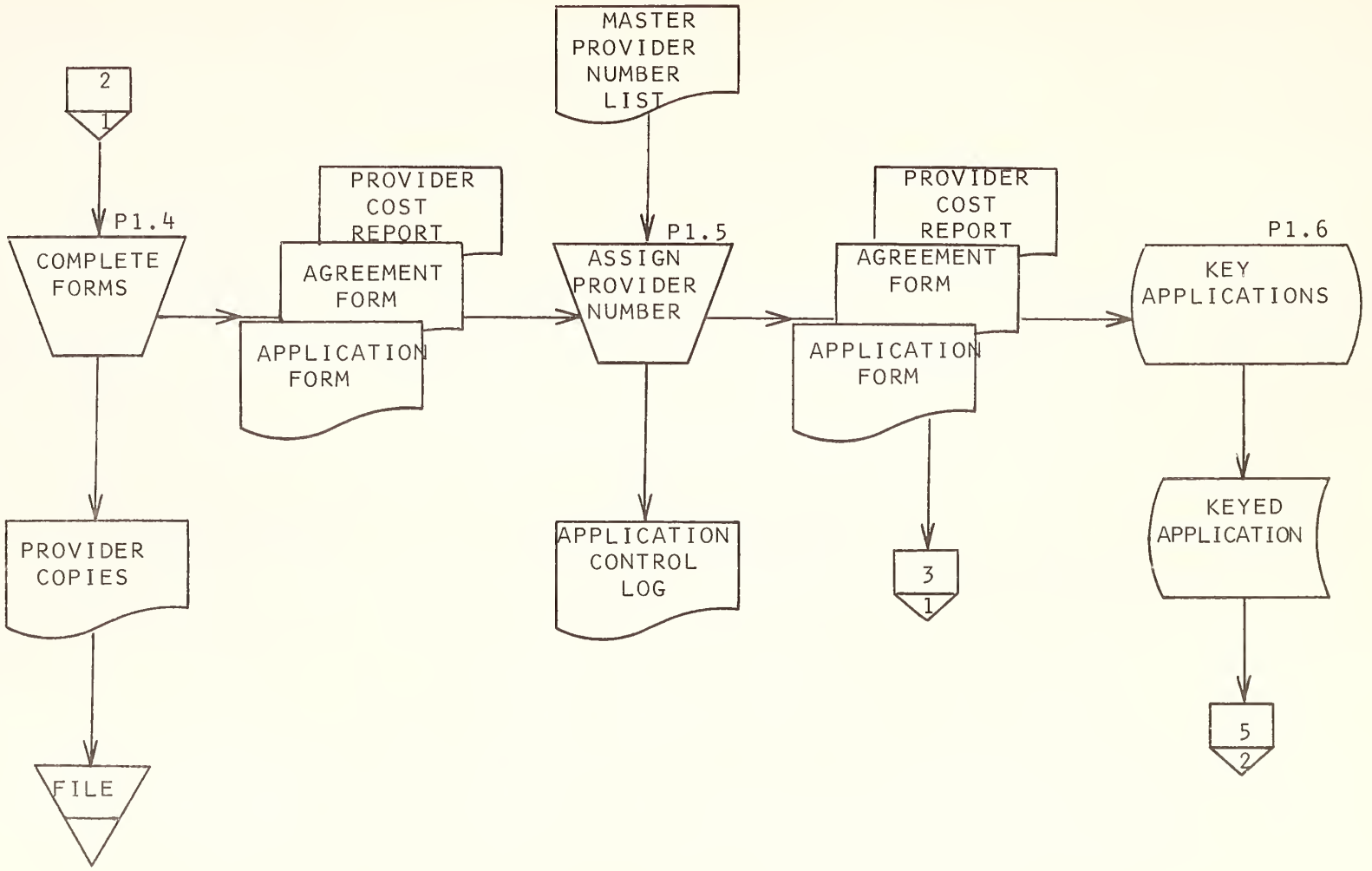
e. Provider Applications Pending Report.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - CERTIFICATION MODULE	

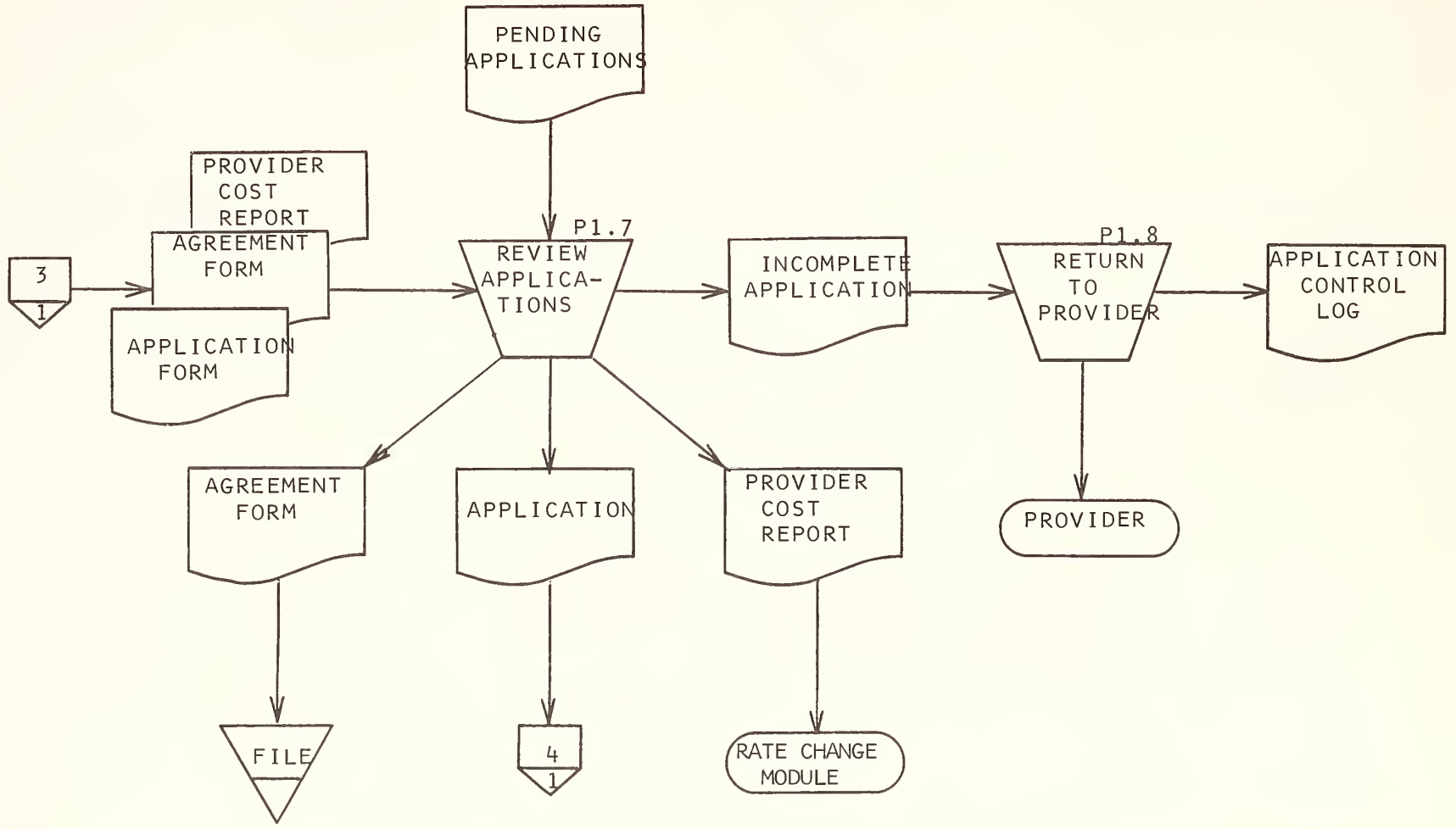


III-19

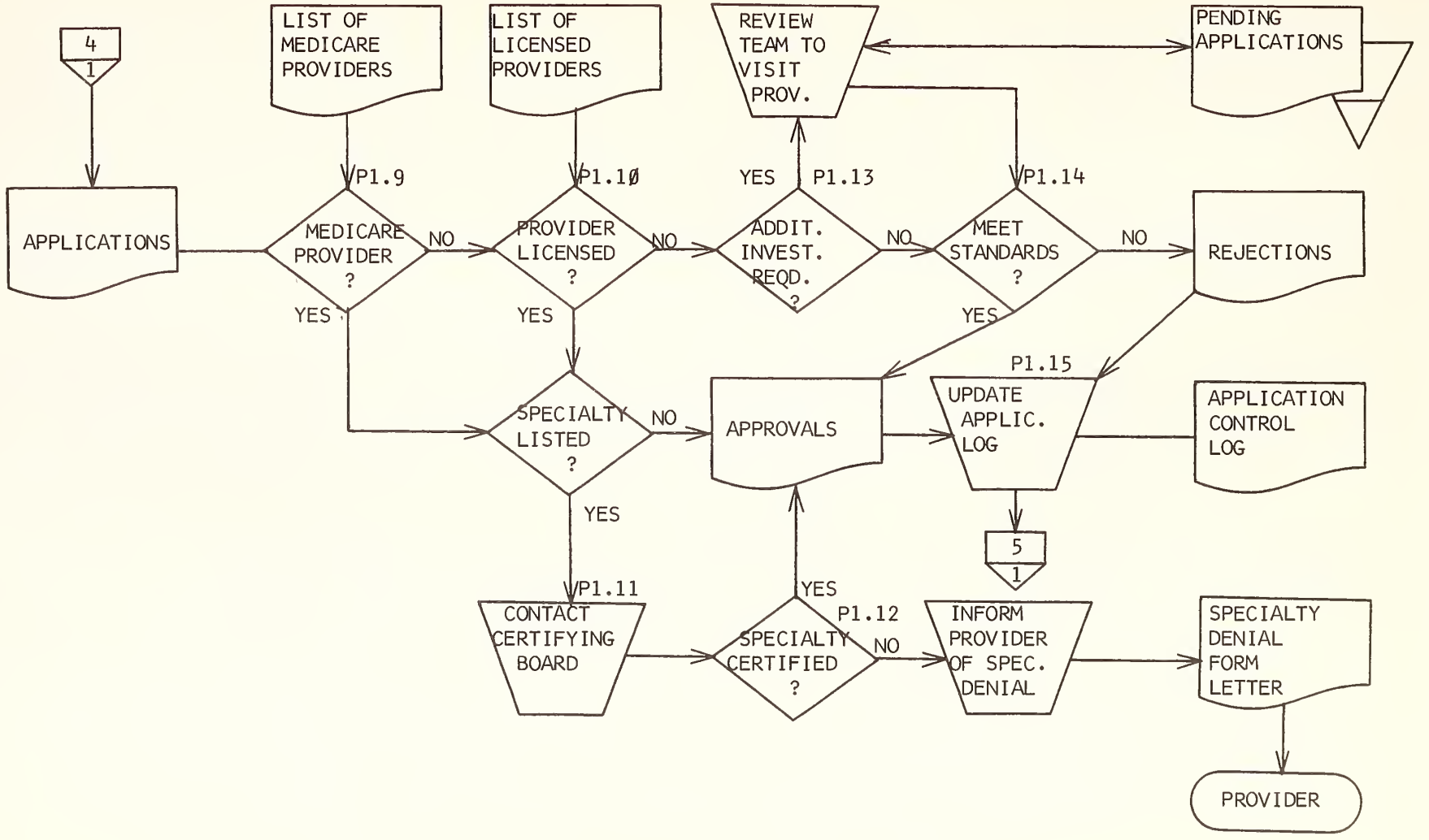
MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - CERTIFICATION MODULE	



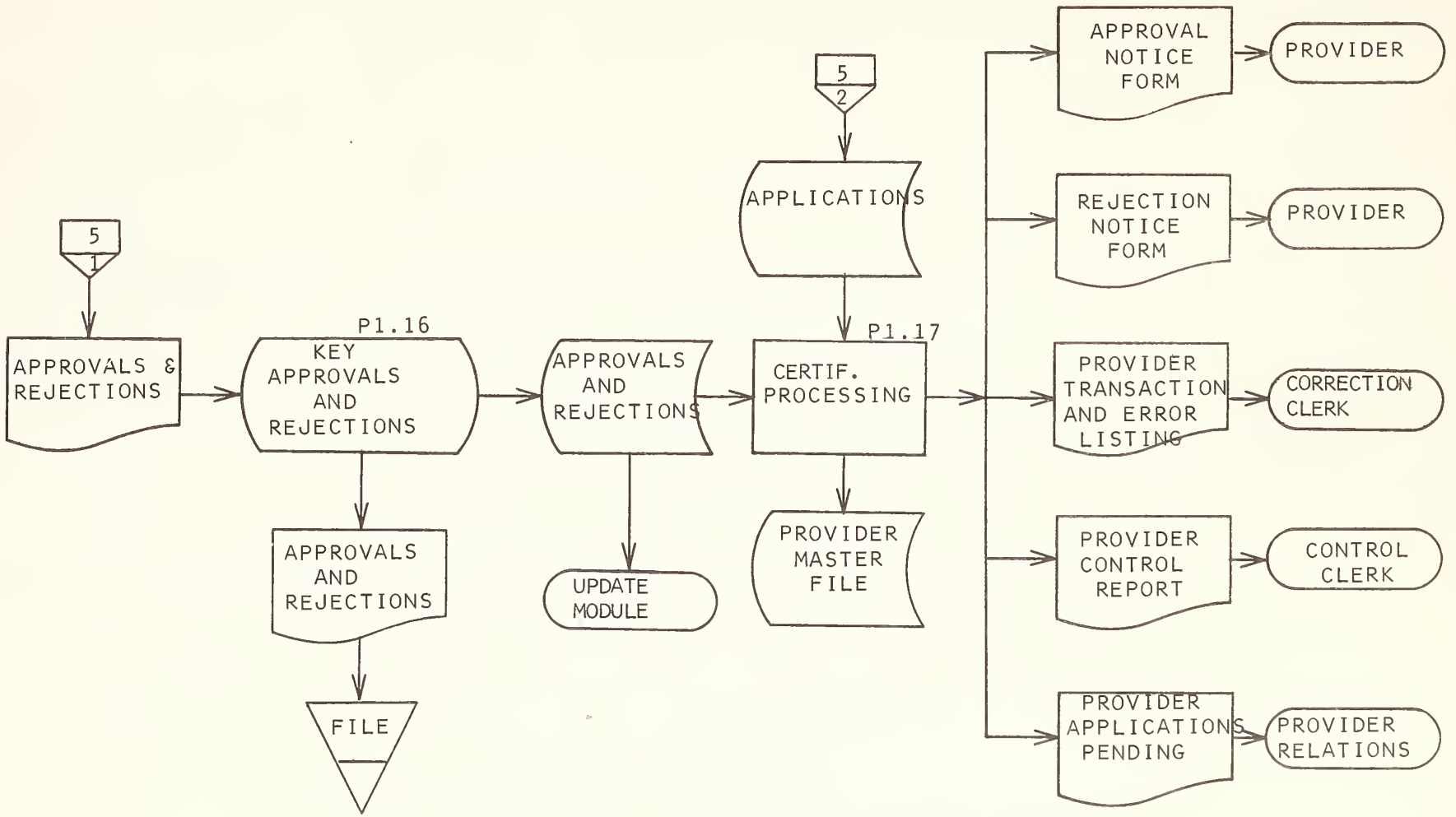
MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - CERTIFICATION MODULE	



SUBSYSTEM PROVIDER SUBSYSTEM - CERTIFICATION MODULE



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - CERTIFICATION MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Provider Subsystem - Certification Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P1.1	Provider	Request, by telephone or letter, information concerning enrollment in the Medicaid Program.
P1.2	Provider Edit Clerk	Accept request for enrollment, check Provider Correspondence File for any other activity by this provider and establish a folder for each new provider.
P1.3	Provider Edit Clerk	Prepare cover letter and send application packet with cover letter to provider.
P1.4	Provider	Complete application form, sign agreement and if the application is for an institutional provider fill out the Provider Cost Report. Keep provider copy of all forms and send State copies to Single State Agency.
P1.5	Provider Edit Clerk	Receive application packet from provider. Assign a provider number to this provider from the Master Provider Number List and enter provider number on application forms. Add the total of new applications received to the applications control log. Send application to data preparation section for keying.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Certification Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P1.6	Data Preparation Section	Key and verify application data into machine readable form.
P1.7	Provider Edit Clerk	Screen application packet for completeness and correct minor errors. Make certain that agreement is signed or that a previously signed agreement is already on file at the Single State Agency. If all forms are properly completed, file agreement form in provider correspondence file and hold rate sheet for further processing (see Step P3.6).
P1.8	Provider Edit Clerk	If application is incomplete, enter number of applications being returned on applications control log and return application to provider with a cover letter explaining that the provider has not been rejected but he is merely advised that he can not be accepted as a Medicaid provider until all application forms are complete.
P1.9	Provider Edit Clerk	If the application form indicates that the provider has already been certified as eligible for Medicare and a check of a list of Medicare providers verifies this fact, the provider is accepted for Medicaid.
P1.10	Provider Edit Clerk	If the provider is not a Medicare provider, but the provider is licensed by the State and verified by checking a list of licensed providers, the provider is accepted for Medicaid. If out of State provider, check with other State's licensing agency.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Certification Module	

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P1.11	Provider Edit Clerk	If the provider (practitioner) lists a specialty, contact the proper Certifying Board to verify that the provider is certified to practice the specialty.
P1.12	Provider Edit Clerk	If the specialty is not certified by the proper Board, send form letter to provider and mark through specialty on application form.
P1.13	Provider Review Team	If provider is neither a Medicare provider nor licensed by a State Agency, a visit to the provider to determine whether provider meets Medicaid standards may be necessary.
P1.14	Provider Review Team	If provider meets Medicaid standards, accept provider, otherwise reject application and code rejection reason on application form.
P1.15	Provider Edit Clerk	Complete coding of application form (for example, code specialty). Update applications control log with number of applications approved and rejected. Send approved and rejected applications to data preparation section.
P1.16	Data Preparation Section	Key and verify approvals and rejections into machine readable form.
P1.17	Data Processing	Edit data for completeness and consistency.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Certification Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P1.17 (Cont)	Data Processing	Update Provider Master File with new applications, approvals and rejections. Print Approval Notice Form or Rejection Notice Form and send to provider. Print Provider Applications Pending Report and send to provider relations manager for use in controlling the flow of work through his area. Print a Transaction and Error List and send to error correction clerk for error correction (see Step P2.4). Print a Provider Control Report and send to provider control clerk for reconciliation with applications control log (see Step P2.8).

EDIT AND UPDATE MODULE

Functions

The Edit and Update Module performs the following functions:

a. Processes changes from providers, certifying agencies, and Single State Agency personnel.

b. Updates the Provider Master File with the most current information available.

c. Identifies incomplete or erroneous data.

d. Corrects incomplete or erroneous data if possible or returns it to the sender for correction.

e. Controls the manual and data processing functions to ensure that all transactions are processed correctly.

Outputs

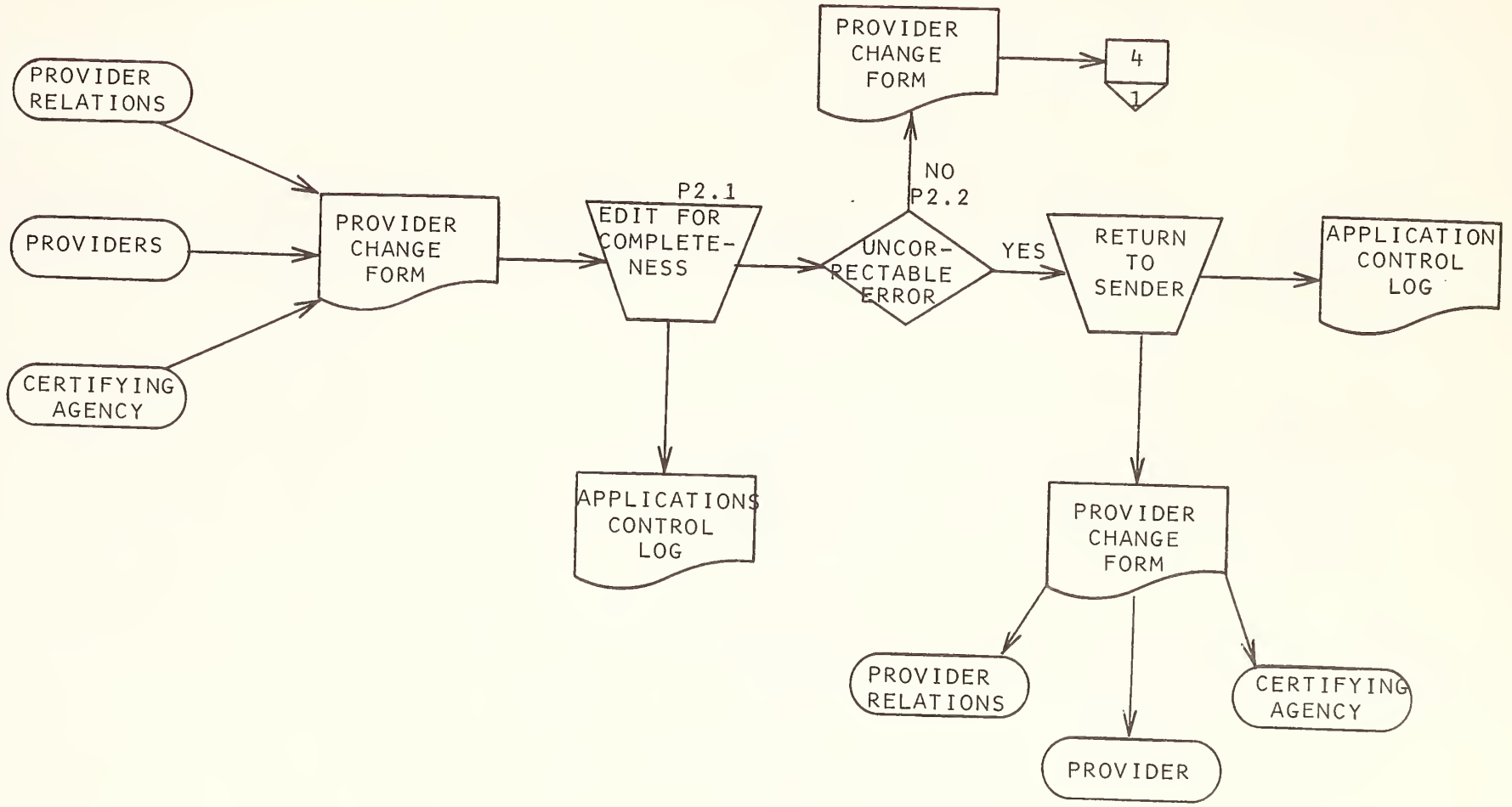
The Edit and Update Module produces the following major outputs:

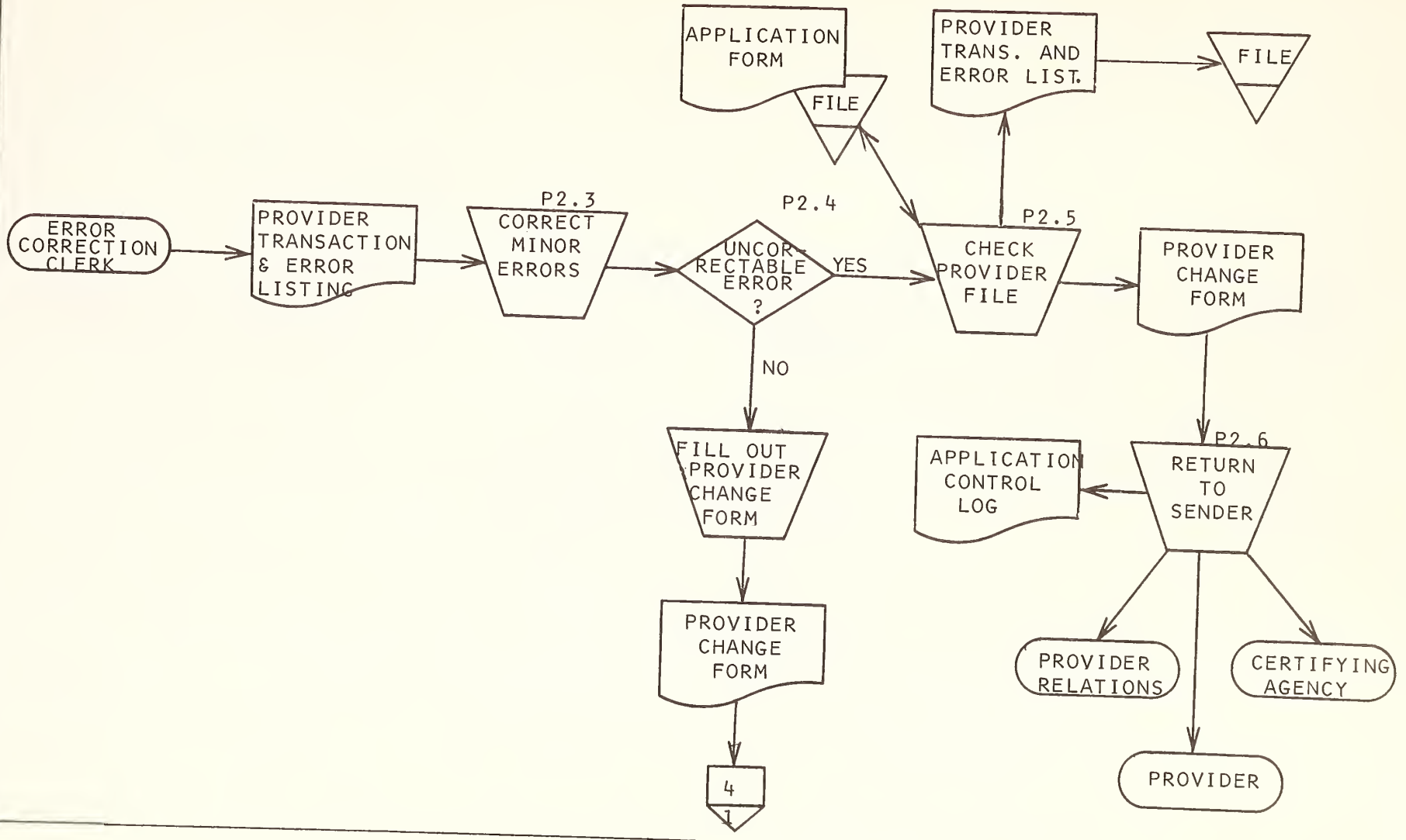
a. Provider Information Sheet.

b. Provider Transaction and Error List.

c. Provider Control Report.

d. Aged Provider Error Listing.

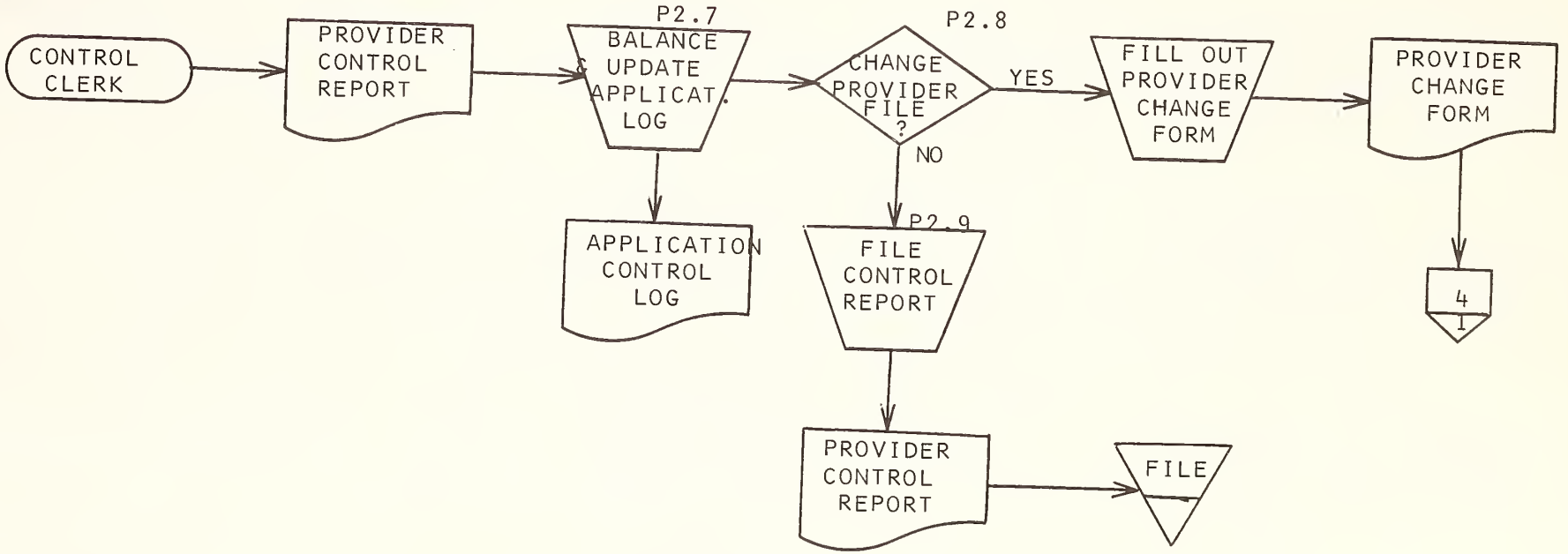

PROVIDER RELATIONS
PROVIDERS
CERTIFYING AGENCY
PROVIDER CHANGE FORM
P2.1
EDIT FOR COMPLETE-NESS
APPLICATIONS CONTROL LOG
UNCOR-RECTABLE ERROR
NO
P2.2
PROVIDER CHANGE FORM
4
1
YES
RETURN TO SENDER
APPLICATION CONTROL LOG
PROVIDER CHANGE FORM
PROVIDER RELATIONS
PROVIDER
CERTIFYING AGENCY

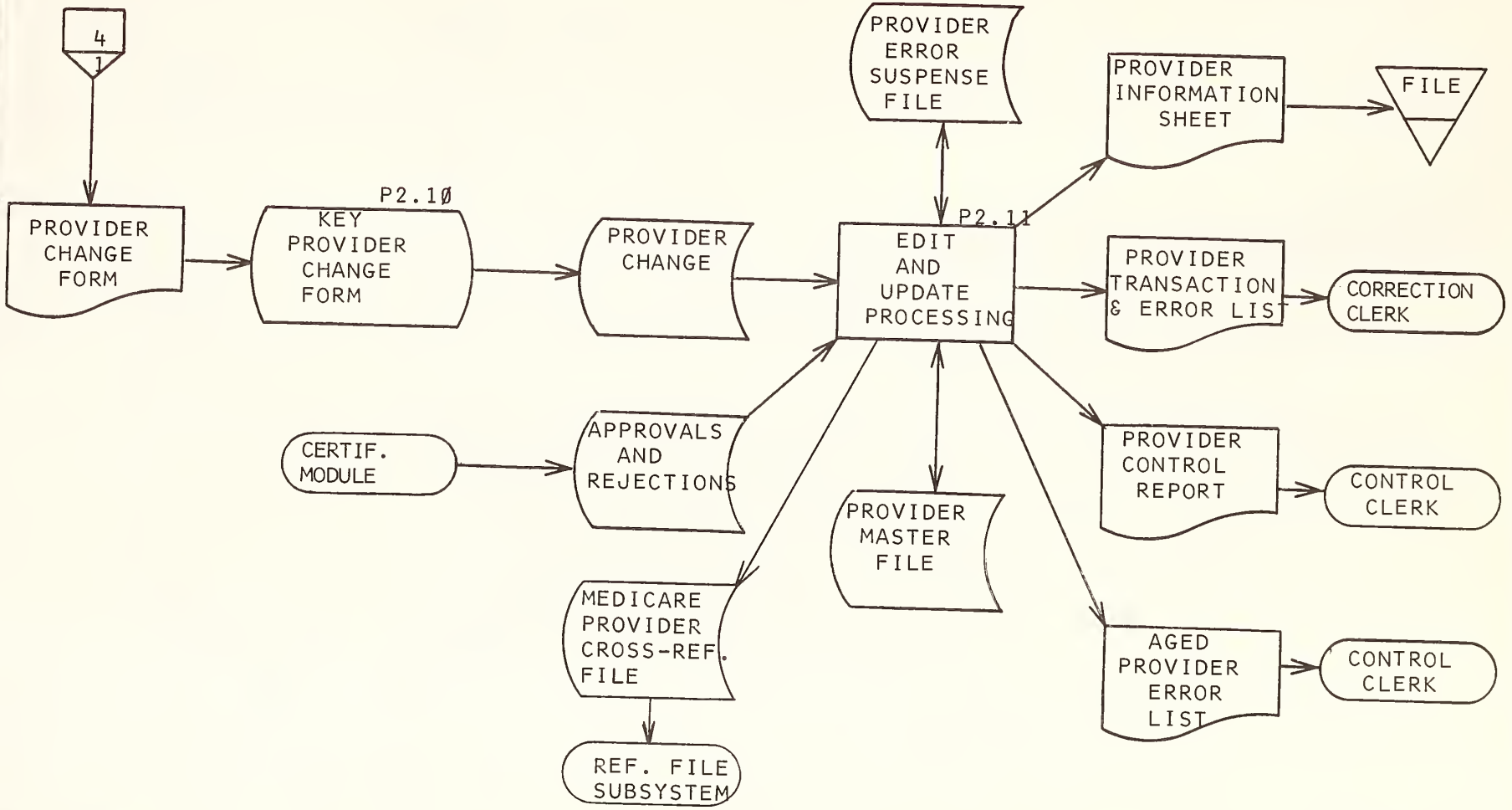

APPLICATION FORM
FILE
PROVIDER TRANS. AND ERROR LIST.
FILE
ERROR CORRECTION CLERK
PROVIDER TRANSACTION & ERROR LISTING
P2.3
CORRECT MINOR ERRORS
P2.4
UNCORRECTABLE ERROR ?
YES
P2.5
CHECK PROVIDER FILE
PROVIDER CHANGE FORM
NO
FILL OUT PROVIDER CHANGE FORM
APPLICATION CONTROL LOG
P2.6
RETURN TO SENDER
PROVIDER CHANGE FORM
PROVIDER RELATIONS
CERTIFYING AGENCY
4
1
PROVIDER

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOWCHART

SUBSYSTEM PROVIDER SUBSYSTEM - EDIT AND UPDATE MODULE




4
1
PROVIDER CHANGE FORM
P2.1Ø
KEY PROVIDER CHANGE FORM
PROVIDER CHANGE
P2.11
EDIT AND UPDATE PROCESSING
PROVIDER ERROR SUSPENSE FILE
PROVIDER INFORMATION SHEET
FILE
PROVIDER TRANSACTION & ERROR LIST
CORRECTION CLERK
CERTIF. MODULE
APPROVALS AND REJECTIONS
PROVIDER MASTER FILE
PROVIDER CONTROL REPORT
CONTROL CLERK
MEDICARE PROVIDER CROSS-REF. FILE
AGED PROVIDER ERROR LIST
CONTROL CLERK
REF. FILE SUBSYSTEM

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Edit and Update Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P2.1	Provider Edit Clerk	Receive Provider Change Forms from: 1. Provider relations personnel who need to flag a provider's record. 2. Providers who need to make a change to their record. 3. Certifying agencies who need to change a certification of specialty or to recertify. Screen change form for completeness and correct minor errors. Enter number of change forms received on Applications Control Log.
P2.2	Provider Edit Clerk	For all forms that are properly completed, send change forms to data preparation section for keying. For all change forms that are incomplete, enter number of change forms that are incomplete on the Applications Control Log and return change forms to the sender.
P2.3	Error Correction Clerk	Work from Provider Transaction and Error Listing from previous update processing run (see Step P2.11) to correct all minor errors such as keying mistakes.
P2.4	Error Correction Clerk	For all errors correctable at this time, fill out a correction form and send it to data preparation section for keying.
P2.5	Error Correction Clerk	For all errors not correctable at this time, pull a copy of the

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P2.5 (Cont.)	Error Correction Clerk	original application form or change form in error, circle the error on the form and fill out provider change form. File the Provider Transaction and Error Listing.
P2.6	Error Correction Clerk	Return forms to originator of change form and make entry on Applications Control Log.
P2.7	Control Clerk	Work with Provider Control Report from previous update processing run (see Step P2.11) and balance computer generated control totals against manual totals on Applications Control Log. If control totals are not in balance and the Applications Control Log is in error, make correction to Applications Control Log.
P2.8	Control Clerk	If control totals are not in balance and the Provider Control Report is in error, fill out error correction form to correct the error in the next update run and send error correction form to data preparation section for keying.
P2.9	Control Clerk	After making any adjusting entry on the Provider Control Report to reflect changes generated on the error correction form in Step P2.8 above, file the Provider Control File.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Edit and Update Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P2.10	Data Preparation Section	Receive Provider Change Forms and error correction forms. Key changes and corrections into machine readable form.
P2.11	Data Processing	Process approvals and rejections from the Provider Certification Module (Step P1.16) and changes and corrections from Step P2.10 above. Edit data for completeness and consistency. Update Provider Master File with all valid transactions. Update Medicare Provider Cross-Reference File whenever a Medicare Provider Number is changed or a new Medicare provider is added. Retain all transactions in error on the Provider Error Suspense File. Release error records from the Provider Error Suspense File as the errors from previous runs are corrected. Print a Provider Information Sheet showing the current status of the provider's record to be filed in the Provider Correspondence File. Print an Aged Provider Error Listing for use by error correction clerk for follow-up on unreturned documents. Print a Provider Transaction and Error List which serves as an audit trail of all transactions processed and identify any transactions having errors, and send this list to the error correction clerk for error correction (see Steps P2.3-P2.6). Print a Provider Control Report which is sent to the provider control clerk to balance against manual control totals on the Applications Control Log (see Steps P2.7-P2.9) to ensure that all changes are properly accounted for.

RATE CHANGE MODULE

Functions

The Rate Change Module performs the following major functions:

a. Processes transactions affecting the rate schedules of institutional providers.

b. Updates the Provider Master File with the most current rate information.

c. Provides the facility for correcting erroneous or incomplete data concerning provider rates.

Outputs

The Rate Change Module produces the following major outputs:

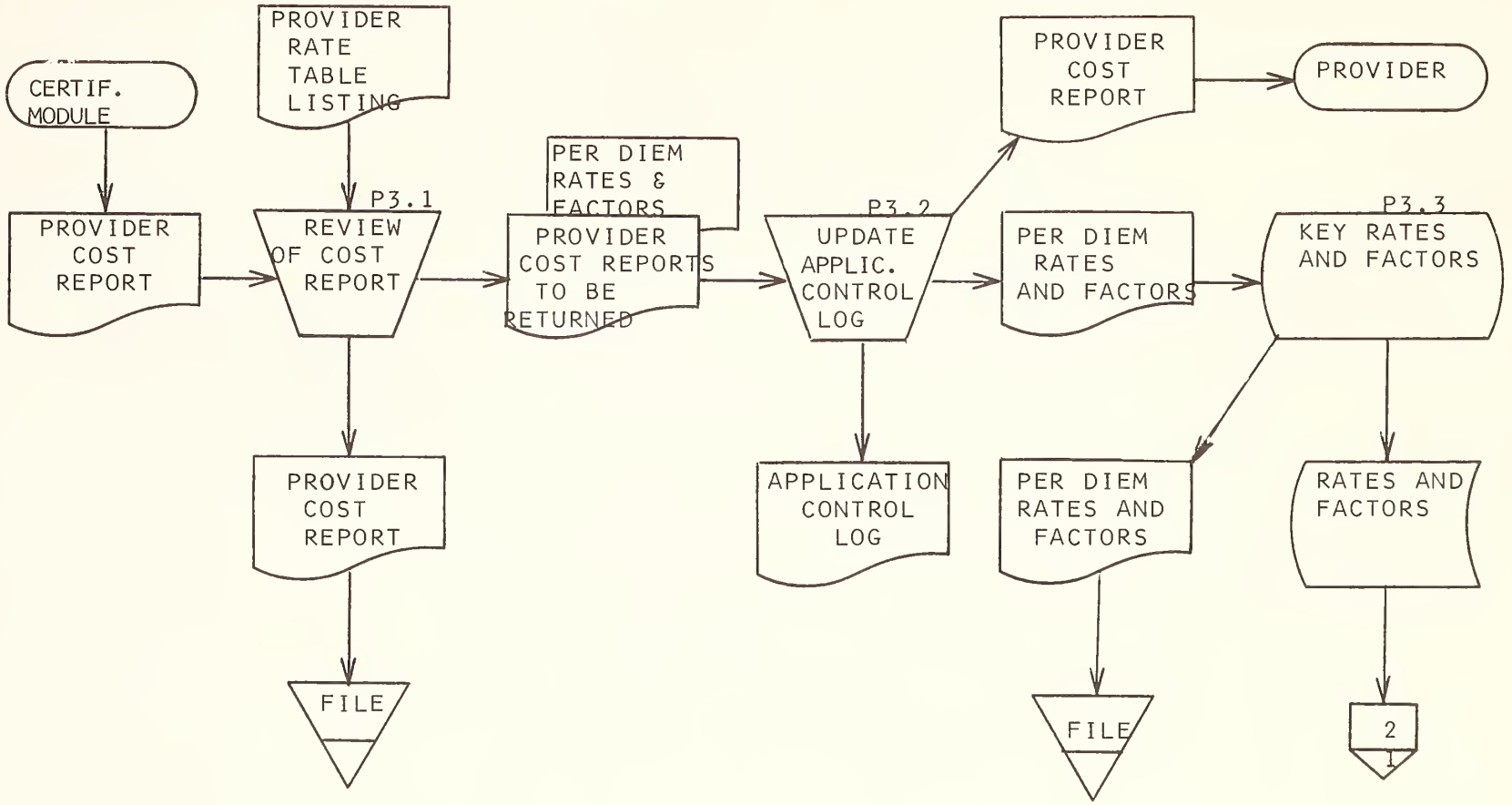
a. Provider Transaction and Error List.

b. Provider Control Report.

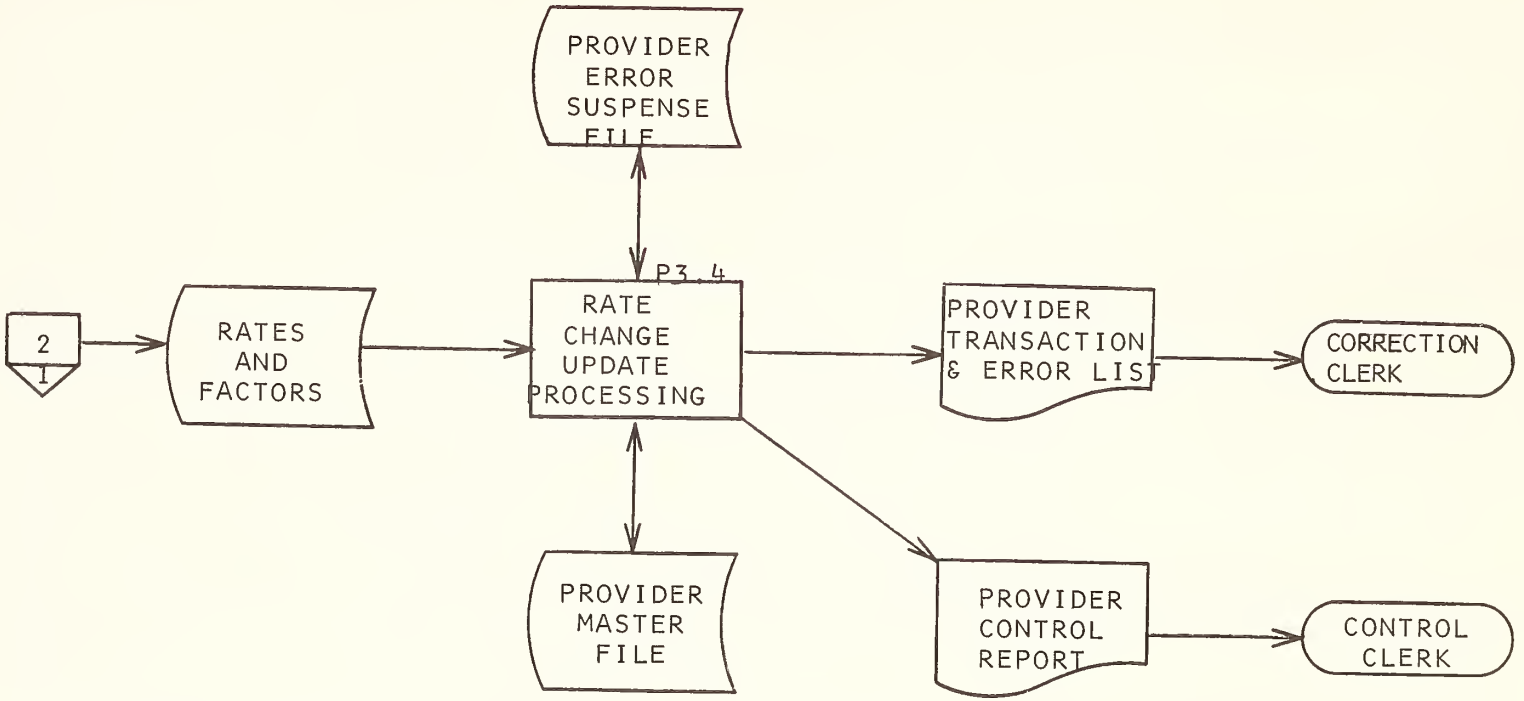
MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOWCHART

SUBSYSTEM PROVIDER SUBSYSTEM - RATE CHANGE MODULE



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - RATE CHANGE MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESS STEP DEFINITION

SUBSYSTEM Provider Subsystem - Rate Change Module

PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P3.1	Cost Settlement Personnel	Receive from the Provider Certification Module (see Step P1.7) the Provider Cost Settlement Report. Review the Cost Settlement Report and establish the per diem rates and factors. Route any Cost Settlement Report which is incomplete to the control clerk for return to the provider. Complete the Per Diem Rates and Factors Sheet for all acceptable cost reports, forward the Per Diem Rates and Factors Sheet to the control clerk and file the Cost Settlement Report.
P3.2	Control Clerk	Receive from cost settlement personnel the Provider Per Diem Rates and Factors Sheets and the Provider Cost Reports to be returned to the provider. Update the Applications Control Log. Return the Provider Cost Reports to the provider. Send all Per Diem Rates and Factors Sheets to the data preparation section for keying.
P3.3	Data Preparation Section	Receive Provider Per Diem Rates and Factors Sheets from provider edit clerk. Key rates and factors into machine readable form.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Rate Change Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P3.4	Data Processing	Edit rates and factors transactions for completeness and consistency, Update Provider Master File with all valid transactions. Retain all transactions in error on the Provider Error Suspense File. Release error records from the Provider Error Suspense File as the errors from previous runs are corrected. Print rate change transactions on the Provider Transaction and Error List with errors noted on the list and send this list to the error correction clerk for error correction (see Steps P2.3-P2.6). Print a Provider Control Report which is sent to the provider control clerk to balance against manual controls on the applications control log (see Steps P2.7-P2.9) to ensure that all transactions are properly accounted for.

REPORTING MODULE

Functions

The Reporting Module performs the following major functions:

a. Consolidates information into a meaningful form.

b. Prints reports for use by provider edit clerks, provider relations personnel, and surveillance and utilization review personnel to assist them in their daily operations.

c. Prints Provider Address Labels on request to use in mailing informational material to all providers.

d. Produces a copy of the Provider Master File, if needed, to send to other processing functions who would have need for this data.

Outputs

The Reporting Module produces the following major outputs:

a. Alphabetical Provider Listing.

b. Numeric Provider Listing.

c. Provider Rate Table Listing.

d. Provider Enrollment Summary.

e. Annual Recertification Notice.

f. Provider Listing Group Affiliation.

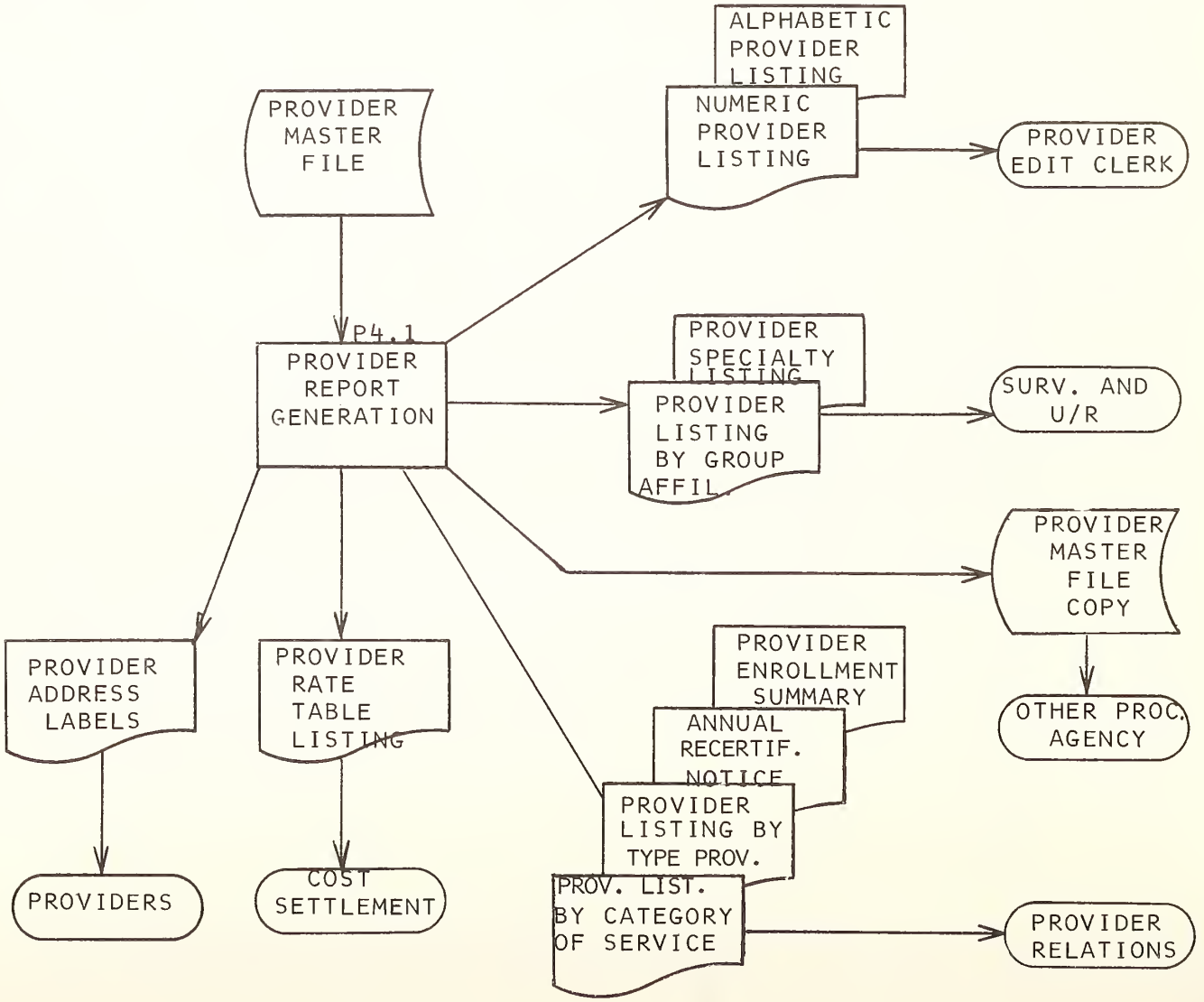
g. Provider Specialty Listing.

h. Provider Address Labels.

i. Provider Listing by Category of Service.

j. Provider Listing by Type Organization.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOWCHART
SUBSYSTEM PROVIDER SUBSYSTEM - REPORTING MODULE	



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION		PROCESS STEP DEFINITION
SUBSYSTEM	Provider Subsystem - Reporting Module	
PROCESS STEP NO.	RESPONSIBILITY	ACTIVITY
P4.1	Data Processing	Print the Alphabetic Provider List and the Numeric Provider List for the provider edit clerk to use to check provider numbers and to answer inquiries concerning providers. Print Annual Recertification Notices and a Provider Enrollment Summary to enable provider relations personnel to keep track of their workload regarding certification and recertification of providers. Print a Provider Listing by Group Affiliation and a Provider Specialty Listing to be used by surveillance and utilization review personnel as reference material for the selection of provider profiles. Print Provider Address Labels (when requested) to be used for mailing informational material to providers. Print Provider Rate Table Listings for use by cost settlement personnel in their annual cost settlement audit of institutional providers. Make a copy of the Provider Master File and send to other processing agencies (if any exist). Print Provider List by Type Provider and Provider List by Category of Service for use by provider relations.

D. SUBSYSTEM OUTPUTS

The Provider Subsystem produces the outputs listed below. The purpose, distribution, and sequence of each output are presented on an Output Definition Sheet. Whenever practical this sheet is followed by a sample report layout that describes the general format and content of the report. The data displayed on the reports are entirely fictitious with little regard given to reasonableness or cross footing of the numbers. The purpose of the sample data is solely one of assistance to the reader in more readily gaining an understanding of the report. The three digit numbers that appear on each report are data element numbers identifying the data elements contained within that report. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

Output Number	Output Name	Page Number
PS-0-Ø1	Approval Notice Form	III-58
PS-0-Ø2	Rejection Notice Form	III-60
PS-0-Ø3	Provider Transaction and Error Listing	III-62
PS-0-Ø4	Provider Control Report	III-64
PS-0-Ø5	Provider Applications Pending	III-66
PS-0-Ø6	Provider Information Sheet	III-68
PS-0-Ø7	Aged Provider Error List	III-70
PS-0-Ø8	Numeric Provider Listing	III-72
PS-0-Ø9	Alphabetic Provider Listing	III-74
PS-0-10	Provider Listing by Type Provider	III-77
PS-0-11	Provider Listing by Category of Service	III-80
PS-0-12	Provider Enrollment Summary	III-82
PS-0-13	Annual Recertification Notice	III-84
PS-0-14	Provider Specialty Listing	III-86

Output Number	Output Name	Page Number
PS-0-15	Provider Listing by Group Affiliation	III-88
PS-0-16	Provider Address Labels	III-90
PS-0-17	Provider Rate Table Listing	III-92

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Approval Notice Form	PS-O-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Certification Module Processing Step P1.17	Weekly (if required)
	MEDIA
	Preprinted form

DISTRIBUTION

1.	Provider Correspondence File
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This output is a form letter which is sent to a provider showing that he has been certified as a Medicaid provider.

REMARKS

APPROVAL NOTICE

08/01/71

202 DR. JOHN T. WILLIAMS 1234567 201
1010 MAIN STREET
203 ANYWHERE, USA 10101

YOUR APPLICATION FOR ENROLLMENT IN THE (STATE) MEDICAID PROGRAM HAS BEEN APPROVED BY THE (SINGLE STATE AGENCY), EFFECTIVE 01/01/71.

YOU ARE AUTHORIZED TO PROVIDE THE FOLLOWING SERVICES:

SERVICE	SPECIALTY
205 PHYSICIAN	OBSTETRICS 220

ALL FUTURE COMMUNICATIONS WITH THE (SINGLE STATE AGENCY) REGARDING YOUR PARTICIPATION IN THE (STATE) MEDICAID PROGRAM SHOULD CONTAIN YOUR PROVIDER IDENTIFICATION NUMBER. YOUR PROVIDER NUMBER IS:

1234567

THIS NUMBER IS PERMANENTLY ASSIGNED TO YOU AS LONG AS YOU PARTICIPATE IN THE (STATE) MEDICAID PROGRAM. IF FOR ANY REASON YOU SHOULD LEAVE THE PROGRAM AND SUBSEQUENTLY REAPPLY, THIS NUMBER SHOULD BE INDICATED ON YOUR APPLICATION.

TO ASSIST US IN MAINTAINING AN ACCURATE RECORD OF YOUR PROVIDER DATA, ALL CHANGES PERTAINING TO THE INFORMATION REQUESTED ON THE ENROLLMENT APPLICATION MUST BE SUBMITTED IN WRITING TO THE (SINGLE STATE AGENCY).

ACCOMPANYING THIS LETTER IS A PROVIDER MANUAL AND AN INITIAL SUPPLY OF CLAIM FORMS. THE PROVIDER MANUAL WAS DEVELOPED TO ASSIST YOU WITH COMPLETION OF THE CLAIM FORMS AND TO OUTLINE THE BASIC POLICIES AND PROCEDURES OF THE (STATE) MEDICAID PROGRAM. YOU WILL RECEIVE REVISIONS TO THE MANUAL AS CHANGES OCCUR IN THE MEDICAID PROGRAM.

ADDITIONAL CLAIM FORMS SHOULD BE REQUESTED FROM THE MEDICAID DEPARTMENT OF THE (SINGLE STATE AGENCY).

ANY QUESTIONS REGARDING PARTICIPATION IN THE (STATE) MEDICAID PROGRAM SHOULD BE DIRECTED TO THE PROVIDER RELATIONS OFFICE OF THE (SINGLE STATE AGENCY).

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-01

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Rejection Notice Form	PS-O-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Certification Module Processing Step P1.17	Weekly (if required)
	MEDIA Preprinted form

DISTRIBUTION

1.	Provider
2.	Provider Correspondence File
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This output is a form letter which is sent to a provider whose application to participate in the Medicaid program has been denied.

REMARKS

REJECTION NOTICE

08/01/71

202 DR. SAM SINGLETON 1234567 201
1010 MAIN STREET
203 ANYWHERE, USA 10101

YOUR APPLICATION FOR ENROLLMENT IN THE (STATE) MEDICAID PROGRAM HAS BEEN DENIED FOR THE FOLLOWING REASON:

229 THE SERVICES YOU PROVIDE ARE NOT PRESENTLY COVERED IN THE (STATE) MEDICAID PROGRAM.

WHILE WE CANNOT ENROLL YOU AS A PROVIDER IN THE (STATE) MEDICAID PROGRAM AT THIS TIME, SHOULD THE CONDITIONS WHICH CAUSED YOUR APPLICATION TO BE DENIED BE CORRECTED, WE WOULD BE GLAD TO PROCESS YOUR NEW REQUEST. THIS WILL, HOWEVER, REQUIRE THE COMPLETION OF A NEW APPLICATION AND AGREEMENT.

PLEASE CONTACT THE PROVIDER RELATIONS OFFICE OF THE (SINGLE STATE AGENCY) IF YOU HAVE ANY QUESTIONS REGARDING THE ABOVE ACTION.

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-02

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Transaction and Error Listing	PS-O-Ø3
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73

SOURCE OF OUTPUT DATA	FREQUENCY
Certification Module Processing Step P1.17	Weekly (if required)
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Error Correction Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report is used as an audit trail of provider activity and as an error listing which is used for correcting errors for resubmission.

REMARKS

RUN DATE 08/01/71

PAGE 1

P R O V I D E R T R A N S A C T I O N A N D E R R O R L I S T I N G

PROVIDER NUMBER	TRANSACTION DATE	CODE	PROVIDER NAME	ERROR FIELD	ERROR FIELD CONTENTS	ERROR REASON
1234567	07/05/71	10	DR. MARCUS JONES MD	005	91	INVALID PROVIDER TYPE
				010	12345678	INVALID PROVIDER SOCIAL SECURITY NUMBER
2345678	07/05/71	12	DR. CARL DANIELS	NONE		
1462738	07/05/71	10	DR. THOMAS LAW	1002		DUPLICATE RECORD DETECTED
201	243	242	202	244		245

III-63

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-03

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Control Report	PS-O-Ø4
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73
SOURCE OF OUTPUT DATA	**FREQUENCY**
Certification Module Processing Step P1.17	Weekly (if required)
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Control Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Type	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report provides control to ensure that all provider activity is properly entered into the system. It includes a count of providers by type and a count of transactions by type transaction.

REMARKS

RUN DATE 08/01/71

PAGE 1

PROVIDER CONTROL REPORT

PROVIDER TYPE	PREVIOUS TOTAL	PROVIDERS ADDED	PROVIDERS DELETED	PROVIDERS CHANGED	NEW TOTAL	TOTAL TRANSACTIONS	TOTAL ERRORS	TOTAL SUSPENDED
01 INPATIENT HOSPITAL	1,234	12	3	123	1,243	138	8	12
02 MENTAL HOSPITAL	12	2	1	3	13	6	1	1

205

III-65

REPORT FORMAT SAMPLE

OUTPUT NO. PS-0-04

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Applications Pending	PS-O-Ø5
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Certification Module Processing Step P1.17	After each update
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Type	4.	
2.	Provider Application Date	5.	
3.	Provider Name	6.	

PURPOSE OF OUTPUT

This report is an aged list of provider applications pending a decision. It provides a measure of the backlog of work for the certifying agency.

REMARKS

RUN DATE 08/01/71

PROVIDER APPLICATIONS PENDING

PROVIDER NUMBER	PROVIDER NAME	PROVIDER TYPE	SPECIALTY	APPLICATION DATE
1234567	DR. CALVIN C. WILLIAMS	01 02	01	03/12/71
1617189	DR. FELIX J. JOHNSON	01	13	03/22/71
2233448	DR. FRANK W. FARNHAM, DDS	08		02/14/71
201	202	205	220	228

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-05

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Information Sheet	PS-O-Ø6
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Edit and Update Module Processing Step P2.11	After each update
	MEDIA Stock Paper

DISTRIBUTION

1.	Provider Correspondence File
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This form contains all provider data as it appears on the Provider Master File. This form is filed in a folder for each provider along with any correspondence with the provider.

REMARKS

P R O V I D E R I N F O R M A T I O N S H E E T

PROVIDER NUMBER	PROVIDER NAME AND ADDRESS	PAY TO NAME AND ADDRESS	GROUP NAME AND ADDRESS	PER DIEM AND PERCENT OF CHARGES INPATIENT	OUTPATIENT	EFFECTIVE DATE
	202					
1234567	GENERAL HOSPITAL	HOSPITAL BILLING SERVICE		$50.00	75.00%	03/01/71
	1010 MAIN STREET	1111 FIRST AVENUE	246	45.00	75.00%	06/01/69
201	ANYWHERE, USA 10101	ANYWHERE, USA 10101		30.00	60.00%	01/01/66
	203	204		233	234	235

CATEGORY OF SERVICE		EFFECTIVE DATE	ENDING DATE	
301 01 INPATIENT	207	01/01/66		
02 OUTPATIENT		01/01/66		
03 TB	238	01/01/66	10/01/70	208
PROVIDER STATUS	ACTIVE	01/01/66	239	

CERTIFICATION SPECIALTY	BOARD	NUMBER	EFFECTIVE DATE
NONE	NONE	NONE	NONE
220	222	221	223

PROVIDER TYPE	205	01	OWNERSHIP CODE		1	GROUP NUMBER	NONE 209
TYPE OF PRACTICE	210	CORPORATION	PLACE OF SERVICE CODE		02	NUMBER IN GROUP	NONE 241
EMPLOYER ID NUMBER	212	123456789	NUMBER OF BEDS	232	540	CREDIT BALANCE AMT.	NONE 226
SOCIAL SECURITY NO.	213	NONE	PROVIDER COUNTY CODE	211	02	CREDIT BALANCE DATE	NONE 227
MEDICARE PROVIDER NO.	214	1234567	FISCAL YEAR END	216	12/31/71	NURSING HOME OWNERS	S. J. SMITH 250
MEDICARE REIMBURSEMENT RATE		$ 50.00 215	LAST TRANSACTION	224	10/01/70		T. J. BROWN
LICENSE BOARD	218	01	EXCEPTION INDICATOR	225	NO	REVIEW COMMITTEE MEMBERS	251
LICENSE NUMBER	217	123456789	OUT OF STATE PROVIDER	230	NO		A. A. JONES
LICENSE DATE	219	01/01/29	LOCATION CODE	236	012		B. Y. BLACK
NATIONAL PHARMACY NO.	231	123456	CONTROL OF FACILITY	237	CHARITY		D. A. REDD
APPLICATION DATE	228	01/01/66	REJECTION REASON CODE	229	NONE		

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-06

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Aged Provider Error List	PS-O-Ø7
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Edit and Update Module Processing Step P2.11	After each update
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Control Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Transaction Date	4.	
2.	Provider Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report is a listing of all Provider Master File records that are awaiting a correction to a transaction. This report should ensure that all transaction errors are corrected.

REMARKS

RUN DATE 08/01/71

PAGE 1

A G E D P R O V I D E R E R R O R L I S T

TRANSACTION DATE	TRANS CODE	PROVIDER NUMBER	PROVIDER NAME	ERROR FIELD	ERROR FIELD CONTENTS	ERROR REASON
07/05/71	10	1234567	DR. MARCUS JONES MD.	005	91	INVALID PROVIDER TYPE
				010	12345678	INVALID PROVIDER SOCIAL SECURITY NUMBER
07/05/71	12	1462738	DR. THOMAS LAW	1002		DUPLICATE RECORDS DETECTED
243	242	201	202	244		245

III-71

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-07

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Numeric Provider Listing	PS-O-Ø8
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	After each update
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Edit Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report provides a list of all Medicaid providers. It is used to answer inquiries and to assist in error correction.

REMARKS

RUN DATE 08/01/71

NUMERIC PROVIDER LISTING

PROVIDER NUMBER	PROVIDER NAME	STREET ADDRESS	CITY AND STATE	PROV TYPE	CATEGORIES OF SERVICE	COUNTY CODE	STATUS	EFFECTIVE DATE
1234569	GENERAL HOSPITAL	100 BROADWAY NE	ANYWHERE, USA	01	01 03 04	01	ACTIVE	09/23/70
2357890	ARLINGTON MUNICIPAL	1563 LAWRENCE HWY	ARLINGTON, USA	02	01 03	18	ACTIVE	01/01/69
1238873	WILLIAMSTOWN HOSPITAL	POWDER HORN DR	WILLIAMSTOWN, USA	01	01 04	06	INACTIVE	07/30/70
201	202	203		205	301	211	238	239

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-08

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Alphabetic Provider Listing	PS-O-Ø9
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	After each update
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Edit Clerk
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Name	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report is used to determine a provider's number when only the provider's name is known. It is used in conjunction with the Numeric Provider Listing to answer inquiries about Medicaid providers.

REMARKS

RUN DATE 08/01/71

A L P H A B E T I C P R O V I D E R L I S T I N G

PROVIDER NUMBER	PROVIDER NAME	STREET ADDRESS	CITY AND STATE	PROV TYPE	CATEGORIES OF SERVICE	COUNTY CODE	STATUS	EFFECTIVE DATE
1234567	ABC CITY HOSPITAL	225 NORTH AVE SW	LOUDON, USA	01	01 02 03	01	ACTIVE	09/23/70
4567891	BROWNVILLE GENERAL HOSPITAL	MAIN STREET	BROWNVILLE, USA	01	01 02	77	ACTIVE	01/01/66
6789123	COOPER COUNTY HOSPITAL	ROUTE 17	COOPERTOWN, USA	01	01 02	15	ACTIVE	06/01/67
201	202	203		205	301	211	238	239

REPORT FORMAT SAMPLE

OUTPUT NO. PS-0-09

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Listing by Type Provider	PS-0-1Ø
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations
2.	Surveillance and Utilization Review
3.	
4.	
5.	

SEQUENCE

1.	Provider Type	4.	
2.	Provider Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This is a report that will be referenced by Provider Relations or Surveillance and Utilization Review.

REMARKS

RUN DATE 08/01/71

PROVIDER LISTING BY PROVIDER TYPE

***** HOSPITALS *******

NUMBER	PROVIDER NAME	CITY AND STATE	OWNERSHIP	STATUS	DATE
1234567	GENERAL HOSPITAL	ANYWHERE, USA	PUBLIC	ACTIVE	09/23/70
4553218	KINGSTONE HOSPITAL	TOLEDO, USA	PROPRIETORY	ACTIVE	10/01/67
1789213	MASHALL GENERAL	MORRISTOWN, USA	PUBLIC	ACTIVE	02/07/66
201	202	203	237	238	239

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-10

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Listing by Category of Service	PS-0-11
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations
2.	Surveillance and Utilization Review
3.	
4.	
5.	

SEQUENCE

1.	Category of Service	4.	
2.	Provider Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This is a report that will be referenced by Provider Relations or Surveillance and Utilization Review.

REMARKS

RUN DATE 08/01/71

PROVIDER LISTING BY CATEGORY OF SERVICE

* * * * DRUGS * * * *

PROVIDER NUMBER	PROVIDER NAME	CITY AND STATE	PROV TYPE	COUNTY CODE	STATUS	EFFECTIVE DATE
1234567	ABC PHARMACY, INC	ANYWHERE, USA	10	01	ACTIVE	09/23/70
2367891	ARROW DRUGS	SUMMERVILLE, USA	10	26	ACTIVE	03/01/70
6789123	BOWENS PHARMACY	REDDING, USA	10	13	ACTIVE	12/15/68
201	202	203	205	211	238	239

I8-III

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-11

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Enrollment Summary	PS-0-12
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	Monthly
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Type	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows for each provider type the additions and deletions of providers on a monthly basis. It is used to project trends in provider enrollment and to help to gauge provider dissatisfaction as evidenced by withdrawals from the Medicaid program.

REMARKS

RUN DATE 08/01/71

PROVIDER ENROLLMENT SUMMARY

PROVIDER TYPE	TOTAL PROVIDERS	ADDITIONS DURING MONTH	DELETIONS DURING MONTH	CHANGES DURING MONTH
01 INPATIENT HOSPITAL	1,234	12	3	123
02 MENTAL HOSPITAL	12	2	1	3

205

REPORT FORMAT SAMPLE

OUTPUT NO. PS-D-12

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Annual Recertification Notice	PS-0-13
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Reporting Module Processing Step P4.1	As required
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Specialty Certification Boards
2.	Licensing Agencies
3.	
4.	
5.	

SEQUENCE

1.	Licensing Agency or Certification Board
2.	License or Certification Number

PURPOSE OF OUTPUT

This report is a listing of providers licensed by a licensing agency or certified by a certification board. The report would be forwarded to the licensing agency or certification board for verification of continued license or certification.

REMARKS

RUN DATE 08/01/71

ANNUAL RECERTIFICATION UPDATE NOTICE

* * * * LICENSE BOARD 01 PHYSICIANS * * * *

PROVIDER NUMBER	PROVIDER NAME	CITY AND STATE	LICENSE NUMBER	CERTIFICATION BOARD AND NO.	PROVIDER TYPE	SPECIALTY CODES	APPLICATION DATE
1234567	DR. MARCUS JONES	ANYWHERE, USA	123456789	01 123456789	05	01	09/20/67
2678912	DR. ANDREW SMITH	LONGVIEW, USA	456789102	11 478912345	06	08	10/13/69
4455667	DR. LAWRENCE VINING	MIDDLETOWN, USA	998877665	18 172635422	05	02	12/17/67
201	202	203	217	222 221	205	220	228

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-13

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Specialty Listing	PS-0-14
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Reporting Module Processing Step P4.1	As required
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Surveillance and Utilization Review
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Specialty Code	4.	
2.	Provider Name	5.	
3.		6.	

PURPOSE OF OUTPUT

This report is a reference listing for Surveillance and Utilization Review.

REMARKS

RUN DATE 08/01/71

PROVIDER LISTING BY PRACTICE SPECIALTY

****** OBSTETRICS *****

PROVIDER NUMBER	PROVIDER NAME	CITY AND STATE	SPECIALTY CODES	PROV TYPE	CNTY CODE	LICENCE NUMBER	LICENCE BOARD	EFF DATE	CERTIFICATION NUMBER	BOARD
1234567	DR JOHN T. JAMESON	ANYWHERE, USA	01 05	01	01	123456789	01	09/16/61	123456789	01
2324778	DR FRED T. GRAHAM	MARION, USA	05	01	24	234567890	11	10/06/63	987654321	11
8223493	DR ROBERT THOMPSON, JR	SLIDDEL, USA	05	01	13	543435621	10	05/19/62	123678421	10
201	202	203	220	205	211	217	218	219	221	222

III-87

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-14

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Listing by Group Affiliation	PS-0-15
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Reporting Module Processing Step P4.1	As required
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Surveillance and Utilization Review
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Group Number	4.	
2.	Provider Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This report is used in the Surveillance and Utilization Review process to identify providers who are members of a group practice, or who are hospital-based physicians, or who are members of a Health Maintenance Organization.

REMARKS

RUN DATE 08/01/71

PROVIDER LISTING BY GROUP AFFILIATION

* * * * * HOSPITAL BASED PHYSICIANS * * * * *

GROUP NUMBER	GROUP NAME AND ADDRESS	PROVIDER NUMBER	PROVIDER NAME	PROVIDER ADDRESS	COUNTY CODE	SPECIALITY CODES
1234567	GENERAL HOSPITAL ANYWHERE, USA	7654321	DR WILLIAM ADAMS	ANYWHERE, USA	01	01
		2545689	DR SAMUEL ABRAMS	ANYWHERE, USA	01	02
		4567123	DR CARL C. KILPATRICK	ANYWHERE, USA	03	04
1366720	LOUDON HOSPITAL RIDGEFIELD,USA	1267810	DR FRANK CANARY	LAKE CITY, USA	15	02
		4362130	DR THOMAS GARROWAY	LAKE CITY, USA	15	03
209	246	**201**	202	203	**211**	**220**

68-III

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-15

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Address Labels	PS-0-16
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SOURCE OF OUTPUT DATA	**FREQUENCY**
Reporting Module Processing Step P4.1	As required
	MEDIA
	Special Form

DISTRIBUTION

1.	Requestor
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Type	4.	
2.	Provider Number	5.	
3.		6.	

PURPOSE OF OUTPUT

This output consists of an address label for each provider which is used for mass mailings of manuals, instructions, or letters to all providers, or all providers of a given type.

REMARKS

PROVIDER ADDRESS LABELS

PROVIDER TYPE	PROVIDER NUMBER	PROVIDER NAME
01	1234567	GENERAL HOSPITAL 1010 MAIN STREET ANYWHERE, USA 10101
01	2678912	RIVERBEND GENERAL HOSPITAL 1422 LANGLEY HIGHWAY COLLIERSVILLE, USA 16002

205 201 202 203

I6-III

REPORT FORMAT SAMPLE

OUTPUT NO. PS-O-16

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

OUTPUT DEFINITION

OUTPUT NAME	OUTPUT NO.
Provider Rate Table Listing	PS-0-17
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SOURCE OF OUTPUT DATA	FREQUENCY
Reporting Module Processing Step P4.1	After each update
	MEDIA
	Stock Paper

DISTRIBUTION

1.	Provider Relations Cost Settlement Department
2.	
3.	
4.	
5.	

SEQUENCE

1.	Provider Number	4.	
2.		5.	
3.		6.	

PURPOSE OF OUTPUT

This report shows for each institutional provider with a per diem or percent of charges rate structure, the most current rate and the effective date, as well as previous rates and their effective dates.

REMARKS

PROVIDER RATE TABLE LISTING

****** HOSPITALS ******

PROVIDER NUMBER	PROVIDER NAME AND ADDRESS	PER DIEM RATES OR PERCENT OF CHARGES INPATIENT	OUTPATIENT	EFFECTIVE DATE	NUMBER OF BEDS	MEDICARE NUMBER	MEDICARE RATE
1234567	GENERAL HOSPITAL 1010 MAIN STREET ANYWHERE, USA 10101	$ 50.00 $ 45.00 $ 30.00	75.00 % 75.00 % 60.00 %	03/01/71 05/01/70 03/01/69	516	1234567	$ 50.00
2678912	RIVERBEND GENERAL HOSPITAL 1422 LANGLEY HIGHWAY COLLIERSVILLE, USA 16002	$ 12.00	75.00 %	04/01/67	285	4567890	$ 70.00
201	202	203	233	234	235	232	214	215

REPORT FORMAT SAMPLE

OUTPUT NO. PS-D-17

E. SUBSYSTEM INPUTS

The Provider Subsystem receives the inputs listed below. The purpose and source of each input are presented on an Input Definition Sheet. This sheet is followed by an Input Description Form that indicates the data elements that are introduced into the system by means of this input. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements, and, where applicable, a recommended coding structure can be found in the Appendix.

Input Number	Input Name	Page Number
PS-I-Ø1	Provider Application Form	III-95
PS-I-Ø2	Provider Agreement Form	III-98
PS-I-Ø3	Provider Cost Report	III-100
PS-I-Ø4	Provider Change Form	III-102
PS-I-Ø5	Per Diem Rates and Factors Sheet	III-104
PS-I-Ø6	Master Provider Number List	III-106
PS-I-Ø7	List of Medicare Providers	III-108
PS-I-Ø8	List of Licensed Providers	III-110

INPUT DEFINITION

INPUT NAME	INPUT NO.
Provider Application Form	PS-I-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SEQUENCE	FREQUENCY
In Order of Arrival	Daily (As necessary)
	MEDIA
	Pre-printed form

SOURCE OF INPUT DATA

Medicaid provider applicants
Process Step P1.3

PURPOSE OF INPUT

The Provider Application Form is used by Medicaid provider applicants to record all provider data required by the Medicaid program.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Application Form	PS-I-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
204	Provider Pay to Address		X
205	Provider Type	X	
301	Category of Service	X	
	(as many as ten different categories of service		
	may be entered)		
207	Beginning Date of Service	X	
209	Provider Group Number		X
210	Provider Type of Practice Organization		X
211	Provider County Code	X	
212	Provider Employer Identification Number	X	
213	Provider Social Security Number	X	
214	Medicare Provider Number		X
217	Provider License Number		X
218	Provider License Board Code		X
219	Provider License Date		X
220	Provider Specialty Code	X	
221	Specialty Certification Number		X
222	Specialty Certification Board Code		X
223	Specialty Certification Date		X
	(as many as three different specialities may be entered)		
225	Provider Exception Indicator		X
228	Provider Application Date		X
229	Provider Rejection Reason Code		X

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Application Form	PS-I-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
230	Out of State Provider Code		X
231	National Pharmacy Number		X
232	Number of Beds Certified		X
236	Provider Location Code	X	
237	Control of Medical Facility		X
238	Provider Enrollment Status Code	X	
239	Provider Enrollment Status Date	X	
241	Number Physicians in Group		X
242	Provider Transaction Code	X	
246	Provider Group Name and Address		X
250	Nursing Home Owners	X	
251	Review Committee Members	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Provider Agreement Form	PS-I-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
In order of arrival	Daily (as necessary)
	MEDIA
	Preprinted form

SOURCE OF INPUT DATA

Medicaid provider applicants
Process Step P1.3

PURPOSE OF INPUT

This form, when signed by the provider, establishes an understanding between the provider and the Single State Agency as to the requirements and responsibilities of the provider and the Single State Agency for participation in the Medicaid program.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Agreement Form	PS-I-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
249	Provider Signature	X	
	In addition, any statements of agreement required by		
	the Single State Agency may also be included.		

INPUT DEFINITION

INPUT NAME	INPUT NO.
Provider Cost Report	PS-I-Ø3
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
In order of arrival	Daily (as required)
	MEDIA
	Preprinted form

SOURCE OF INPUT DATA

Medicaid providers and provider applicants
Process Step P1.3

PURPOSE OF INPUT

This form is used by Medicaid providers (institutions) to record operating cost data. The cost data is used by the Single State Agency to establish per diem rates and percent of charges factors for interim claims reimbursement.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Cost Report	PS-S-Ø3
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
	Such provider cost data as required to establish		
	or adjust Medicaid per diem rates and percent of		
	charges factors may also be included.		

INPUT DEFINITION

INPUT NAME	INPUT NO.
Provider Change Form	PS-I-Ø4
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Any sequence	Daily (as required)
	MEDIA
	Preprinted form

SOURCE OF INPUT DATA

Surveillance and Utilization Review personnel
Provider relations personnel
Control Clerk (Process Step P2.8)
Error Correction Clerk (Process Step P2.4)

PURPOSE OF INPUT

The Provider Change Form is used by various units within the Single State Agency to make changes (and corrections) as required to the Medicaid Provider Master File. An example would be to set the Provider Exception Indicator on a provider's record so that all future claims for that provider must be manually reviewed prior to payment.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Provider Change Form	PS-I-Ø4
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
242	Provider Transaction Code	X	
247	Provider Transaction Field Number	X	
248	Provider Transaction Field	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Per Diem Rates and Factors Sheet	PS-I-Ø5
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Any sequence	As required
	MEDIA
	Preprinted form

SOURCE OF INPUT DATA

Single State Agency cost settlement personnel

PURPOSE OF INPUT

This is the input form used to update the Provider Master File with per diem rates and percent of charges factors. This form is completed by Single State Agency cost settlement personnel after auditing the Provider Cost Report.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Per Diem Rates and Factors Sheet	PS-I-Ø5
SUBSYSTEM NAME	**DATE**
Provider Subsystem	9/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
215	Provider Medicare Reimbursement Rates		X
216	Provider Year End Date		X
233	Per Diem Rate	X	
234	Percent of Charges Factor	X	
235	Rate Effective Date	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
Master Provider Number List	PS-I-Ø6
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FREQUENCY**
Provider Number	As required
	MEDIA
	Stock paper

SOURCE OF INPUT DATA

Control Clerk
Process Step P1.5

PURPOSE OF INPUT

This list would contain all provider numbers and the name and address of the provider assigned to each number. The list is necessary to control assignment of provider numbers and prevent duplication.

REMARKS

If a provider number with a check digit is used as recommended, the Master Provider Number List could be generated by a one time computer program.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
Master Provider Number List	PS-I-Ø6
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
List of Medicare Providers	PS-I-Ø7
SUBSYSTEM NAME	DATE
Provider Subsystem	8/1/71
SEQUENCE	FREQUENCY
Provider Name	Monthly
	MEDIA: Stock paper

SOURCE OF INPUT DATA

Medicare processing agency (P1.9)

PURPOSE OF INPUT

This list is used in the adjudication of Medicaid provider applications. A provider approved for Medicare would automatically qualify as a provider for Medicaid.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
List of Medicare Providers	PS-I-Ø7
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
202	Provider Name	X	
203	Provider Address	X	
214	Medicare Provider Number	X	

INPUT DEFINITION

INPUT NAME	INPUT NO.
List of Licensed Providers	PS-I-Ø8
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

SEQUENCE	FREQUENCY
Provider Name	Monthly
	MEDIA
	Stock paper

SOURCE OF INPUT DATA

Each State licensing agency

PURPOSE OF INPUT

The list is used to verify that a provider applying for participation in the Medicaid program is licensed, if a license is required for the provider's type of practice.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

INPUT DESCRIPTION

INPUT NAME	INPUT NO.
List of Licensed Providers	PS-I-Ø8
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
202	Provider Name	X	
203	Provider Address		X
217	License Number		X
218	License Date		X
219	License Board Code		X

F. SUBSYSTEM FILES

The Provider Subsystem utilizes the major files listed below. The purpose and nature of each file are presented on a File Definition Sheet. This sheet is followed by a File Description Form that indicates the data element that is maintained within the system by this file. The designation of "minimal" for a data element indicates a data element that is deemed essential in order for the overall system to function properly and in accordance with existing Federal policies and regulations. The designation of "recommended" for a data element specifies a data element that is deemed highly desirable from the standpoint of insuring substantive reports for management, responsible claims processing, and effective surveillance and utilization review activities. Definitions for all data elements and, where applicable, a recommended coding structure can be found in the Appendix.

A Data Element Input/Output Matrix for the Provider Subsystem can be found on the last page in this section. This chart provides a summary of which data elements are introduced through the Provider Subsystem and on which subsystem outputs these data elements are displayed.

File Number	File Name	Page Number
PS-F-Ø1	Provider Master File	III-113
PS-F-Ø2	Provider Error Suspense File	III-116
PS-F-Ø3	Provider Correspondence File	III-118
PS-F-Ø4	Medicare Provider Cross-Reference File	III-12Ø

FILE DEFINITION

FILE NAME	FILE NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Provider Number	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

Update daily if transactions are present.

PURPOSE AND FUNCTION

To retain provider related data to be used by the Claims Processing, Management and Administrative Reporting, and Surveillance and Utilization Review subsystems.

To provide a data base for maintenance, control, and efficient retrieval of information relating to providers.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
204	Provider Pay to Address		X
205	Provider Type	X	
301	Category of Service	X	
207	Beginning Date of Service	X	
208	Ending Date of Service	X	
	(data elements 301 and 207 through 208 are repeated		
	up to 10 times)		
209	Provider Group Number		X
210	Provider Type of Practice Organization		X
211	Provider County Code	X	
212	Provider Employer Identification Number	X	
213	Provider Social Security Number	X	
214	Medicare Provider Number		X
215	Provider Medicare Reimbursement Rates		X
216	Provider Year End Date		X
217	Provider License Number		X
218	Provider License Board Code		X
219	Provider License Date		X
220	Provider Specialty Code	X	
221	Specialty Certification Number		X
222	Specialty Certification Board Code		X
223	Specialty Certification Date		X
	(data elements 220 through 223 are repeated up to		

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Provider Master File	PS-F-Ø1
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
	three times)		
224	Date of Last Transaction		X
225	Provider Exception Indicator		X
226	Provider Credit Balance Amount	X	
227	Provider Credit Balance Date	X	
228	Provider Application Date		X
229	Provider Rejection Reason Code		X
230	Out of State Provider Code		X
231	National Pharmacy Number		X
232	Number of Beds Certified		X
233	Per Diem Rate	X	
234	Percent of Charges Factor	X	
235	Rate Effective Date	X	
	(data elements 233 through 235 are repeated up to		
	five times)		
236	Provider Location Code		X
237	Control of Medical Facility		X
238	Provider Enrollment Status Code	X	
239	Provider Enrollment Status Date	X	
	(data elements 238 and 239 are repeated up to five		
	times)		
241	Number Physicians in Group		X
250	Nursing Home Owners	X	
251	Review Committee Members	X	

FILE DEFINITION

FILE NAME	FILE NO.
Provider Error Suspense File	PS-F-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Provider Number	[X] EDP [ ] MANUAL

UPDATE PROCEDURE

This file is updated each time the Provider Master File is updated.

PURPOSE AND FUNCTION

This file is used to retain all provider file transactions that, because of an error condition, are not applied to the Provider Master File. These transactions are retained until a transaction relieving the error condition is received. The Aged Provider Error Listing is produced from this file.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Provider Error Suspense File	PS-F-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
201	Provider Number	X	
202	Provider Name	X	
203	Provider Address	X	
204	Provider Pay to Address		X
205	Provider Type	X	
301	Category of Service	X	
207	Beginning Date of Service	X	
208	Ending Date of Service	X	
	(data elements 301 and 207 through 208 are repeated		
	up to three times)		
209	Provider Group Number		X
210	Provider Type of Practice Organization		X
211	Provider County Code	X	
212	Provider Employer Identification Number	X	
213	Provider Social Security Number	X	
214	Medicare Provider Number		X
215	Provider Medicare Reimbursement Rate		X
216	Provider Year End Date		X
217	Provider License Number		X
218	Provider License Board Code		X
219	Provider License Date		X
220	Provider Specialty Code	X	
221	Specialty Certification Number		X
222	Specialty Certification Board Code		X
223	Specialty Certification Date		X
	(data elements 220 through 223 are repeated up to		

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Provider Error Suspense File	PS-F-Ø2
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL →	↓
	three times)		
225	Provider Exception Indicator		X
228	Provider Application Date		X
230	Out of State Provider Code		X
231	National Pharmacy Number		X
232	Number of Beds Certified		X
233	Per Diem Rate	X	
234	Percent of Charges Factor	X	
235	Rate Effective Date	X	
	(data elements 233 through 235 are repeated up to		
	five times)		
236	Provider Location Code		X
237	Control of Medical Facility		X
238	Provider Enrollment Status Code	X	
239	Provider Enrollment Status Date	X	
	(data elements 238 and 239 are repeated up to five		
	times)		
241	Number Physicians in Group		X
242	Provider Transaction Code	X	
243	Provider Transaction Date	X	
244	Provider Error Field Indicator	X	
245	Provider Error Code	X	
	(data elements 244 and 245 are repeated 10 times)		
250	Nursing Home Owners	X	
251	Review Committee Members	X	

FILE DEFINITION

FILE NAME	FILE NO.
Provider Correspondence File	PS-F-Ø3
SUBSYSTEM NAME	**DATE**
Provider Subsystem	8/1/71
SEQUENCE	**FILE TYPE**
Provider Number	☐ EDP ☒ MANUAL

UPDATE PROCEDURE

Daily

PURPOSE AND FUNCTION

This file will contain the following:

1. Provider Agreement Form
2. Provider Application Form
3. Provider Cost Report
4. Provider Per Diem Rate and Factors Sheet
5. Provider Change Form
6. Provider Information Sheet
7. Any correspondence relating to a particular provider

The purpose of this file is to provide a repository of all paper work relating to a provider so that provider inquiries may be expeditiously handled.

REMARKS

FILE DEFINITION

FILE NAME	FILE NO.
Medicare Provider Cross-Reference File	PS-F-Ø4
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73
SEQUENCE	**FILE TYPE** [X] EDP [ ] MANUAL
Medicare Provider Number	

UPDATE PROCEDURE

This file is updated by the Provider Edit and Update Module of the Provider Subsystem.

PURPOSE AND FUNCTION

This file is used to convert Medicare provider numbers to Medicaid provider numbers so that Medicare charge data can be used to build the Reasonable and Customary Charge File. This file could also be used if Medicare crossover claims were received on a computerized file from the Medicare carriers or intermediaries to convert Medicare provider numbers to Medicaid numbers.

REMARKS

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

FILE DESCRIPTION

FILE NAME	FILE NO.
Medicare Provider Cross-Reference File	PS-F-Ø4
SUBSYSTEM NAME	**DATE**
Provider Subsystem	12/Ø3/73

ELEMENT NO.	DATA ELEMENTS	RECOMMENDED MINIMAL	
214	Medicare Provider Number	X	
201	Provider Number	X	
209	Group Provider Number		X

MODEL TITLE XIX
MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT
INPUT/OUTPUT MATRIX

SUBSYSTEM NAME
Provider

INPUT: List of Licensed Providers (PS-I-08)	List of Medicare Providers (PS-I-07)	Master Provider Number List (PS-I-06)	Per Diem Rates and Factors Sheet (PS-I-05)	Provider Change Form (PS-I-04)	Provider Cost Report (PS-I-03)	Provider Agreement Form (PS-I-02)	Provider Application Form (PS-I-01)	ELEMENT NUMBER	DATA ELEMENT NAME	OUTPUT: Approval Notice Form (PS-0-01)	Rejection Notice Form (PS-0-02)	Provider Transaction and Error Listing (PS-0-03)	Provider Control Report (PS-0-04)	Provider Applications Pending (PS-0-05)	Provider Information Sheet (PS-0-06)	Aged Provider Error List (PS-0-07)	Numeric Provider Listing (PS-0-08)	Alphabetic Provider Listing (PS-0-09)	Provider Listing by Type Provider (PS-0-10)	Provider Listing by Category of Service (PS-0-11)	Provider Enrollment Summary (PS-0-12)	Annual Recertification Notice (PS-0-13)	Provider Specialty Listing (PS-0-14)	Provider Listing by Group Affiliation (PS-0-15)	Provider Address Labels (PS-0-16)	Provider Rate Table Listing (PS-0-17)
	X	X	X	X	X	X	X	201	Provider Number	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X
X	X	X			X	X	X	202	Provider Name	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X
X		X			X	X	X	203	Provider Address						X		X	X	X	X		X	X	X	X	X
							X	204	Provider Pay To Address						X											
							X	205	Provider Type	X			X	X	X		X	X	X	X	X	X	X	X		X
							X	207	Beginning Date of Service						X		X	X	X	X						
								208	Ending Date of Service						X											
							X	209	Provider Group Number						X									X		
							X	210	Provider Type of Practice or Organization						X				X							
							X	211	Provider County Code						X		X	X		X			X	X		
							X	212	Provider Employer Identification Number						X											
							X	213	Provider Social Security Number						X											
	X						X	214	Medicare Provider Number						X											X
			X					215	Provider Medicare Reimbursement Rate						X												X
			X					216	Provider Year End Date						X											
X							X	217	Provider License Number						X							X	X			
X							X	218	Provider License Board Code						X								X			
X							X	219	Provider License Date						X											
							X	220	Provider Specialty Code	X				X	X							X	X	X		
							X	221	Specialty Certification Number						X							X	X			
							X	222	Specialty Certification Board Code						X							X	X			
							X	223	Specialty Certification Date						X								X			
								224	Date of Last Transaction						X											
							X	225	Provider Exception Indicator						X											
								226	Provider Credit Balance Amount						X											
								227	Provider Credit Balance Date						X											
							X	228	Provider Application Date					X	X							X				
							X	229	Provider Rejection Reason Code		X				X											
							X	230	Out of State Provider Code						X											
							X	231	National Pharmacy Number						X											
							X	232	Number of Beds Certified						X											X
			X					233	Per Diem Rate						X											X
			X					234	Percent of Charges Factor						X											X
			X					235	Rate Effective Date						X											X
							X	236	Provider Location Code						X											
							X	237	Control of Medical Facility						X											
							X	238	Provider Enrollment Status Code						X											
							X	239	Provider Enrollment Status Date						X				X	X						
							X	241	Number Physicians in Group						X											
				X			X	242	Provider Transaction Code		X															
								243	Provider Transaction Date		X															
								244	Provider Error Field Indicator		X															
								245	Provider Error Code		X															
							X	246	Provider Group Name and Address						X								X			
			X					247	Provider Transaction Field Number																	
			X					248	Provider Transaction Field																	
						X		249	Provider Signature																	
							X	250	Nursing Home Owners						X											
							X	251	Review Committee Members						X											
							X	301	Category of Service																	

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INTRODUCTION

MODEL SYSTEM OVERVIEW

RECIPIENT SUBSYSTEM

SUMMARY

DESIGN ELEMENTS

PROCESSING FLOW

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DATA ELEMENT I/O MATRIX

PROVIDER SUBSYSTEM

SUMMARY

DESIGN ELEMENTS

PROCESSING FLOW

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DATA ELEMENT I/O MATRIX